

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 5
 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	15-1324	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/26/2011 TIME 18:43

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:
 JASPER COUNTY HOSPITAL 15-1324

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

 ECR ENCRYPTION INFORMATION
 DATE: 5/26/2011 TIME 18:43

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 EOxbcOVqi1vytFUUwKzRwgnI4IYGtA
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PI ENCRYPTION INFORMATION
 DATE: 5/26/2011 TIME 18:43

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 TCBw10CrjFbdumdZeMgTVIkb0zQ8:8
 wMSQ6259MC0s8Is0

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX
	1	2		3	4
1	HOSPITAL	0	531,176	473,402	156,713
3	SWING BED - SNF	0	101,391	0	0
7	HOSPITAL-BASED HHA	0	0	0	0
9	RHC	0	0	470	0
9 .03	RHC IV	0	0	-2,346	0
100	TOTAL	0	632,567	471,526	156,713

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 1104 EAST GRACE STREET P.O. BOX:
 1.01 CITY: RENSSELAER STATE: IN ZIP CODE: 47978- COUNTY: JASPER

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00	HOSPITAL	15-1324	2.01	2/ 3/2005	N	O	O
04.00	SWING BED - SNF	15-2324		12/31/2005	N	O	N
09.00	HOSPITAL-BASED HHA	15-7149		5/13/1985	N	P	N
12.00	HOSP-BASED HOSPICE	15-1519		3/12/1993			
14.00	HOSPITAL-BASED RHC	15-3990		10/ 7/1999	N	O	N
14.03	HOSPITAL-BASED RHC 4	15-8502		1/ 1/2005	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2010 TO: 12/31/2010
 18 TYPE OF CONTROL 1 2
 9

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? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
 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. 2 Y 15
 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 2
 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 2
 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION (OR APPLICABLE EXTENSION)OF HOLD HARMLESS PAYMENTS UNDER DRG §5105, MIPPA §147, ACA §3121 OR MMEA §108? "Y" FOR YES, AND "N" FOR NO. N
 21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER IN COL 1 "Y" FOR YES AND "N" FOR NO.(SEE INSTRUCTIONS) IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 or MMEA §108? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS) N N
 21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.
 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 OR "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 OR "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

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

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

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

25.09 0000 0.00

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

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

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

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 7/29/1992

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. 1 2 3 4
 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)

28.03 STAFFING % Y/N 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) Y

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

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).

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)? 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

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

TITLE XIX INPATIENT SERVICES

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

- 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). 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? 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? N
- 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? N
- 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD? N
- 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). N

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
50.00 HHA	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: 0
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0
- 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
- 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

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

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). / /

MISCELLANEOUS DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET S-3
I I TO 12/31/2010 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / O/P VISITS / TITLE XVIII 4	NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	21	7,665	183,960.00		2,412		167
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF					1,259		
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	21	7,665	183,960.00		3,671		167
6 INTENSIVE CARE UNIT	4	1,460	35,040.00		330		
11 NURSERY							
12 TOTAL	25	9,125	219,000.00		4,001		167
13 RPCH VISITS							
18 HOME HEALTH AGENCY					9,012		
21 HOSPICE					4,190		
24 WHEATFIELD CLINIC					203		
24 03 BROOK RURAL HEALTH CENT					648		
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			3,622				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			1,259				
4 ADULTS & PED-SB NF			152				
5 TOTAL ADULTS AND PEDS			5,033				
6 INTENSIVE CARE UNIT			379				
11 NURSERY			231				
12 TOTAL			5,643				
13 RPCH VISITS							
18 HOME HEALTH AGENCY			17,489				
21 HOSPICE			4,474				
24 WHEATFIELD CLINIC			5,277				
24 03 BROOK RURAL HEALTH CENT			5,518				
25 TOTAL							
26 OBSERVATION BED DAYS			1,212				
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET 9	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					662	64	1,084
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		314.04			662	64	1,084
13 RPCH VISITS							
18 HOME HEALTH AGENCY		25.20					
21 HOSPICE		1.78					
24 WHEATFIELD CLINIC		4.73					
24 03 BROOK RURAL HEALTH CENT		4.75					
25 TOTAL		350.50					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET S-4
I HHA NO: I TO 12/31/2010 I
I 15-7149 I
COUNTY: I

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	0	0	0
2 UNDUPLICATED CENSUS COUNT		297.00		

TOTAL
5

1 HOME HEALTH AIDE HOURS	0
2 UNDUPLICATED CENSUS COUNT	

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK

HHA NO. OF FTE EMPLOYEES (2080 HRS)

STAFF 1	CONTRACT 2	TOTAL 3
------------	---------------	------------

- 3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)
- 4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)
- 5 OTHER ADMINISTRATIVE PERSONEL
- 6 DIRECTING NURSING SERVICE
- 7 NURSING SUPERVISOR
- 8 PHYSICAL THERAPY SERVICE
- 9 PHYSICAL THERAPY SUPERVISOR
- 10 OCCUPATIONAL THERAPY SERVICE
- 11 OCCUPATIONAL THERAPY SUPERVISOR
- 12 SPEECH PATHOLOGY SERVICE
- 13 SPEECH PATHOLOGY SUPERVISOR
- 14 MEDICAL SOCIAL SERVICE
- 15 MEDICAL SOCIAL SERVICE SUPERVISOR
- 16 HOME HEALTH AIDE
- 17 HOME HEALTH AIDE SUPERVISOR
- 18

HOME HEALTH AGENCY MSA CODES 1 1.01

19 HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD? 0 0

20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON OR AFTER OCTOBER 1, 2000

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2		
21 SKILLED NURSING VISITS	3,378	152	101	54
22 SKILLED NURSING VISIT CHARGES	388,470	17,480	11,615	6,210
23 PHYSICAL THERAPY VISITS	2,215	11	25	11
24 PHYSICAL THERAPY VISIT CHARGES	276,875	1,375	3,125	1,375
25 OCCUPATIONAL THERAPY VISITS	915	5	5	0
26 OCCUPATIONAL THERAPY VISIT CHARGES	114,375	625	625	0
27 SPEECH PATHOLOGY VISITS	130	0	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	17,550	0	0	0
29 MEDICAL SOCIAL SERVICE VISITS	19	3	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	3,420	540	0	0
31 HOME HEALTH AIDE VISITS	1,926	50	4	8
32 HOME HEALTH AIDE VISIT CHARGES	105,449	2,738	219	438
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	8,583	221	135	73
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	906,139	22,758	15,584	8,023
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	387	0	53	5
37 TOTAL NUMBER OF OUTLIER EPISODES	0	4	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	17,007	1,813	222	170

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET S-4
 I HHA NO: I TO 12/31/2010 I
 I 15-7149 I
 COUNTY:

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	0	3,685
22 SKILLED NURSING VISIT CHARGES	0	0	423,775
23 PHYSICAL THERAPY VISITS	0	0	2,262
24 PHYSICAL THERAPY VISIT CHARGES	0	0	282,750
25 OCCUPATIONAL THERAPY VISITS	0	0	925
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	115,625
27 SPEECH PATHOLOGY VISITS	0	0	130
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	17,550
29 MEDICAL SOCIAL SERVICE VISITS	0	0	22
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	3,960
31 HOME HEALTH AIDE VISITS	0	0	1,988
32 HOME HEALTH AIDE VISIT CHARGES	0	0	108,844
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	9,012
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	952,504
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	445
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	4
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	19,212

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED
HEALTH CENTER PROVIDER STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET S-8
I COMPONENT NO: I TO 12/31/2010 I
I 15-3990 I I

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 492 S BIERMA ST
1.01 CITY: WHEATFIELD STATE: IN ZIP CODE: 47978 COUNTY: JASPER
2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	DATE
	1	2
3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)		/ /
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5 HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6 APPALACHIAN REGIONAL COMMISSION		/ /
7 LOOK-ALIKES		/ /
8 OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		
11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.)		

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12 CLINIC			800	1700	800	1700	800	1700	800	1700	800	1700		

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES.

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVIII TITLE XIX

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.

17 HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED
HEALTH CENTER PROVIDER STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET S-8
I COMPONENT NO: I TO 12/31/2010 I
I 15-8502 I I

RHC 4

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 420 E MAIN ST
1.01 CITY: BROOK STATE: IN ZIP CODE: 47922 COUNTY: JASPER
2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	DATE
	1	2
3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)		/ /
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5 HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6 APPALACHIAN REGIONAL COMMISSION		/ /
7 LOOK-ALIKES		/ /
8 OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		
11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.)		

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
12 CLINIC 0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
			800	1700	800	1700	800	1700	800	1700	800	1700		

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES.

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVIII TITLE XIX

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.

17 HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.

HOSPICE IDENTIFICATION DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/26/2011
I	15-1324	I	FROM 1/ 1/2010	I	WORKSHEET	S-9
I	HOSPICE NO:	I	TO 12/31/2010	I		
I	15-1519	I		I		

HOSPICE 1

PART I - ENROLLMENT DAYS

	TITLE XVIII UNDUPLICATED MEDICARE DAYS 1	TITLE XIX UNDUPLICATED MEDICAID DAYS 2	TITLE XVIII UNDUPLICATED SNF DAYS 3	TITLE XIX UNDUPLICATED NF DAYS 4
1 CONTINUOUS HOME CARE				
2 ROUTINE HOME CARE	2,011	35	1,150	888
3 INPATIENT RESPITE CARE	40			
4 GENERAL INPATIENT CARE	81	2		
5 TOTAL HOSPICE DAYS	2,132	37	1,150	888

PART I - ENROLLMENT DAYS (CONTINUED)

	OTHER UNDUPLICATED DAYS 5	TOTAL UNDUPLICATED DAYS 6
1 CONTINUOUS HOME CARE		
2 ROUTINE HOME CARE	235	2,281
3 INPATIENT RESPITE CARE		40
4 GENERAL INPATIENT CARE	32	115
5 TOTAL HOSPICE DAYS	267	2,436

PART II - CENSUS DATA

	TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SNF 3	TITLE XIX NF 4
6 NUMBER OF PATIENTS RECEIVING HOSPICE CARE	77	3	18	11
7 TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE				
8 AVERAGE LENGTH OF STAY (LINE 5 DIVIDED BY LINE 6)	27.69	12.33	63.89	80.73
9 UNDUPLICATED CENSUS COUNT	73	3	16	11

PART II - CENSUS DATA (CONTINUED)

	OTHER 5	TOTAL 6
6 NUMBER OF PATIENTS RECEIVING HOSPICE CARE	19	99
7 TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE		
8 AVERAGE LENGTH OF STAY (LINE 5 DIVIDED BY LINE 6)	14.05	24.61
9 UNDUPLICATED CENSUS COUNT	18	94

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I
I 15-1324 I
I I

I PERIOD: I
I FROM 1/ 1/2010 I
I TO 12/31/2010 I
I PREPARED 5/26/2011
I WORKSHEET A I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		423,807	423,807	42,520	466,327
5	0500 EMPLOYEE BENEFITS		4,765,392	4,765,392		4,765,392
6	0600 ADMINISTRATIVE & GENERAL	2,364,280	2,348,710	4,712,990	-8,579	4,704,411
8	0800 OPERATION OF PLANT	238,144	400,012	638,156		638,156
9	0900 LAUNDRY & LINEN SERVICE	90,589	28,190	118,779		118,779
10	1000 HOUSEKEEPING	441,466	101,552	543,018		543,018
11	1100 DIETARY	372,231	301,097	673,328	-350,512	322,816
12	1200 CAFETERIA				350,512	350,512
14	1400 NURSING ADMINISTRATION	351,388	3,703	355,091		355,091
15	1500 CENTRAL SERVICES & SUPPLY	39,229	-66,817	-27,588		-27,588
16	1600 PHARMACY	391,156	2,112,719	2,503,875		2,503,875
17	1700 MEDICAL RECORDS & LIBRARY	360,551	61,659	422,210		422,210
18	1800 SOCIAL SERVICE	57,577	2,060	59,637		59,637
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	2,234,456	226,291	2,460,747	-363,033	2,097,714
26	2600 INTENSIVE CARE UNIT	622,693	89,232	711,925	-12,308	699,617
33	3300 NURSERY				289,674	289,674
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	486,092	1,256,098	1,742,190	-68,255	1,673,935
39	3900 DELIVERY ROOM & LABOR ROOM				50,056	50,056
41	4100 RADIOLOGY-DIAGNOSTIC	1,012,942	1,374,808	2,387,750	-31,703	2,356,047
44	4400 LABORATORY	799,033	872,563	1,671,596		1,671,596
47	4700 BLOOD STORING, PROCESSING & TRANS.		154,377	154,377		154,377
49	4900 RESPIRATORY THERAPY	812,660	117,201	929,861	-2,940	926,921
50	5000 PHYSICAL THERAPY	1,161,363	190,898	1,352,261	-665,299	686,962
50.01	5001 KV HEALTH & DEMOTTE PT	31,606	10,985	42,591	568,633	611,224
51	5100 OCCUPATIONAL THERAPY				375,511	375,511
51.01	5101 KV HEALTH & DEMOTTE OT				122,771	122,771
52	5200 SPEECH PATHOLOGY				123,220	123,220
52.01	5201 KV HEALTH & DEMOTTE ST				92,569	92,569
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS				246,868	246,868
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				67,889	67,889
56	5600 DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	636,493	217,364	853,857	-128,673	725,184
61	6100 EMERGENCY	883,925	1,200,175	2,084,100	-47,575	2,036,525
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 FAMILY PRACTICE					
63.50	6310 WHEATFIELD CLINIC	244,664	76,768	321,432		321,432
63.53	6313 BROOK RURAL HEALTH CENT	253,185	96,464	349,649		349,649
	OTHER REIMBURS COST CNTRS					
71	7100 HOME HEALTH AGENCY	1,313,515	213,039	1,526,554	-167,789	1,358,765
	SPEC PURPOSE COST CENTERS					
93	9300 HOSPICE		264,675	264,675	167,789	432,464
95	SUBTOTALS	15,199,238	16,843,022	32,042,260	651,346	32,693,606
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES					
98.01	9801 RENSSELAER HEALTH CENTER		-20	-20		-20
99	9900 NONPAID WORKERS					
100	7950 ALTERNACARE	509,485	22,368	531,853		531,853
100.01	7951 DME EQUIPMENT	395,663	537,749	933,412		933,412
100.02	7952 KV HEALTH CENTER	840,738	116,171	956,909	-617,405	339,504
100.04	7954 OTHER NONREIMBURSABLE COST CENTERS		-38	-38		-38
100.05	7955 MEALS ON WHEELS					
100.06	7956 WATER LAB	58,280	18,642	76,922		76,922
100.07	7957 ADVERTISING	126,003	189,574	315,577	-33,941	281,636
101	TOTAL	17,129,407	17,727,468	34,856,875	-0-	34,856,875

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 15-1324
II PERIOD:
I FROM 1/ 1/2010
I TO 12/31/2010I PREPARED 5/26/2011
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-34,134	432,193
5	0500 EMPLOYEE BENEFITS	-304,373	4,461,019
6	0600 ADMINISTRATIVE & GENERAL	-366,945	4,337,466
8	0800 OPERATION OF PLANT		638,156
9	0900 LAUNDRY & LINEN SERVICE		118,779
10	1000 HOUSEKEEPING	-88	542,930
11	1100 DIETARY		322,816
12	1200 CAFETERIA	-66,634	283,878
14	1400 NURSING ADMINISTRATION	-7,300	347,791
15	1500 CENTRAL SERVICES & SUPPLY		-27,588
16	1600 PHARMACY	-101,797	2,402,078
17	1700 MEDICAL RECORDS & LIBRARY	-11,574	410,636
18	1800 SOCIAL SERVICE		59,637
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-33,020	2,064,694
26	2600 INTENSIVE CARE UNIT	-2,175	697,442
33	3300 NURSERY		289,674
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-384,475	1,289,460
39	3900 DELIVERY ROOM & LABOR ROOM		50,056
41	4100 RADIOLOGY-DIAGNOSTIC	-675	2,355,372
44	4400 LABORATORY	-75	1,671,521
47	4700 BLOOD STORING, PROCESSING & TRANS.		154,377
49	4900 RESPIRATORY THERAPY		926,921
50	5000 PHYSICAL THERAPY	-4,013	682,949
50.01	5001 KV HEALTH & DEMOTTE PT		611,224
51	5100 OCCUPATIONAL THERAPY		375,511
51.01	5101 KV HEALTH & DEMOTTE OT		122,771
52	5200 SPEECH PATHOLOGY		123,220
52.01	5201 KV HEALTH & DEMOTTE ST		92,569
54	5400 ELECTROENCEPHALOGRAPHY		
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,954	244,914
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		67,889
56	5600 DRUGS CHARGED TO PATIENTS		
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC	-10,075	715,109
61	6100 EMERGENCY	-834,952	1,201,573
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 FAMILY PRACTICE		
63.50	6310 WHEATFIELD CLINIC	-11,829	309,603
63.53	6313 BROOK RURAL HEALTH CENT		349,649
	OTHER REIMBURS COST CNTRS		
71	7100 HOME HEALTH AGENCY		1,358,765
	SPEC PURPOSE COST CENTERS		
93	9300 HOSPICE		432,464
95	SUBTOTALS	-2,176,088	30,517,518
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		
98.01	9801 RENSSELAER HEALTH CENTER		-20
99	9900 NONPAID WORKERS		
100	7950 ALTERNACARE		531,853
100.01	7951 DME EQUIPMENT		933,412
100.02	7952 KV HEALTH CENTER		339,504
100.04	7954 OTHER NONREIMBURSABLE COST CENTERS		-38
100.05	7955 MEALS ON WHEELS		
100.06	7956 WATER LAB		76,922
100.07	7957 ADVERTISING		281,636
101	TOTAL	-2,176,088	32,680,787

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 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	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
50.01	KV HEALTH & DEMOTTE PT	5001	PHYSICAL THERAPY
51	OCCUPATIONAL THERAPY	5100	
51.01	KV HEALTH & DEMOTTE OT	5101	OCCUPATIONAL THERAPY
52	SPEECH PATHOLOGY	5200	
52.01	KV HEALTH & DEMOTTE ST	5201	SPEECH PATHOLOGY
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	FAMILY PRACTICE	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	WHEATFIELD CLINIC	6310	RURAL HEALTH CLINIC #####
63.53	BROOK RURAL HEALTH CENT	6313	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
93	HOSPICE	9300	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	RENSSELAER HEALTH CENTER	9801	PHYSICIANS' PRIVATE OFFICES
99	NONPAID WORKERS	9900	
100	ALTERNACARE	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	DME EQUIPMENT	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	KV HEALTH CENTER	7952	OTHER NONREIMBURSABLE COST CENTERS
100.04	OTHER NONREIMBURSABLE COST CENTERS	7954	OTHER NONREIMBURSABLE COST CENTERS
100.05	MEALS ON WHEELS	7955	OTHER NONREIMBURSABLE COST CENTERS
100.06	WATER LAB	7956	OTHER NONREIMBURSABLE COST CENTERS
100.07	ADVERTISING	7957	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 151324	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/26/2011 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFETERIA RECLASS	A	CAFETERIA	12	193,771	156,741
2 HOSPICE RECLASS	B	HOSPICE	93	75,330	92,459
3 OB RECLASS	C	NURSERY	33	261,169	28,505
4		DELIVERY ROOM & LABOR ROOM	39	45,130	4,926
5 CHARGEABLE SUPPLIES	D	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		246,868
6					
7					
8					
9					
10					
11					
12 KV CENTER RECLASS	E	KV HEALTH & DEMOTTE PT	50.01	499,600	69,033
13		KV HEALTH & DEMOTTE OT	51.01	107,866	14,905
14		KV HEALTH & DEMOTTE ST	52.01	81,331	11,238
15 ADVERTISING RECLASS	F	ADMINISTRATIVE & GENERAL	6	13,552	20,389
16 PROPERTY INSURANCE	G	NEW CAP REL COSTS-BLDG & FIXT	3		42,520
17 REHAB RECLASS	H	OCCUPATIONAL THERAPY	51	352,404	23,107
18		SPEECH PATHOLOGY	52	115,638	7,582
19		KV HEALTH CENTER	100.02	156,318	10,250
20 IMPLANTABLE DEVICES	I	IMPL. DEV. CHARGED TO PATIENT	55.30		67,889
36 TOTAL RECLASSIFICATIONS				1,902,109	796,412

(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: 151324	PERIOD: FROM 1/ 1/2010 TO 12/31/2010	PREPARED 5/26/2011 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE			A-7 REF 10
			LINE NO	SALARY	OTHER	
	1	6	7	8	9	
1 CAFETERIA RECLASS	A	DIETARY	11	193,771	156,741	
2 HOSPICE RECLASS	B	HOME HEALTH AGENCY	71	75,330	92,459	
3 OB RECLASS	C	ADULTS & PEDIATRICS	25	306,299	33,431	
4						
5 CHARGEABLE SUPPLIES	D	ADULTS & PEDIATRICS	25		23,303	
6		INTENSIVE CARE UNIT	26		12,308	
7		OPERATING ROOM	37		366	
8		RADIOLOGY-DIAGNOSTIC	41		31,703	
9		RESPIRATORY THERAPY	49		2,940	
10		CLINIC	60		128,673	
11		EMERGENCY	61		47,575	
12 KV CENTER RECLASS	E	KV HEALTH CENTER	100.02	688,797	95,176	
13						
14						
15 ADVERTISING RECLASS	F	ADVERTISING	100.07	13,552	20,389	
16 PROPERTY INSURANCE	G	ADMINISTRATIVE & GENERAL	6		42,520	12
17 REHAB RECLASS	H	PHYSICAL THERAPY	50	624,360	40,939	
18						
19						
20 IMPLANTABLE DEVICES	I	OPERATING ROOM	37		67,889	
36 TOTAL RECLASSIFICATIONS				1,902,109	796,412	

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151324	FROM 1/ 1/2010	5/26/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : CAFETERIA RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	350,512	DIETARY	11	350,512	
TOTAL RECLASSIFICATIONS FOR CODE A			350,512				

RECLASS CODE: B
EXPLANATION : HOSPICE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	HOSPICE	93	167,789	HOME HEALTH AGENCY	71	167,789	
TOTAL RECLASSIFICATIONS FOR CODE B			167,789				

RECLASS CODE: C
EXPLANATION : OB RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NURSERY	33	289,674	ADULTS & PEDIATRICS	25	339,730	
2.00	DELIVERY ROOM & LABOR ROOM	39	50,056			0	
TOTAL RECLASSIFICATIONS FOR CODE C			339,730	339,730			

RECLASS CODE: D
EXPLANATION : CHARGEABLE SUPPLIES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	246,868	ADULTS & PEDIATRICS	25	23,303	
2.00			0	INTENSIVE CARE UNIT	26	12,308	
3.00			0	OPERATING ROOM	37	366	
4.00			0	RADIOLOGY-DIAGNOSTIC	41	31,703	
5.00			0	RESPIRATORY THERAPY	49	2,940	
6.00			0	CLINIC	60	128,673	
7.00			0	EMERGENCY	61	47,575	
TOTAL RECLASSIFICATIONS FOR CODE D			246,868	246,868			

RECLASS CODE: E
EXPLANATION : KV CENTER RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	KV HEALTH & DEMOTTE PT	50.01	568,633	KV HEALTH CENTER	100.02	783,973	
2.00	KV HEALTH & DEMOTTE OT	51.01	122,771			0	
3.00	KV HEALTH & DEMOTTE ST	52.01	92,569			0	
TOTAL RECLASSIFICATIONS FOR CODE E			783,973	783,973			

RECLASS CODE: F
EXPLANATION : ADVERTISING RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	33,941	ADVERTISING	100.07	33,941	
TOTAL RECLASSIFICATIONS FOR CODE F			33,941	33,941			

RECLASS CODE: G
EXPLANATION : PROPERTY INSURANCE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	42,520	ADMINISTRATIVE & GENERAL	6	42,520	
TOTAL RECLASSIFICATIONS FOR CODE G			42,520	42,520			

RECLASS CODE: H
EXPLANATION : REHAB RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	OCCUPATIONAL THERAPY	51	375,511	PHYSICAL THERAPY	50	665,299	
2.00	SPEECH PATHOLOGY	52	123,220			0	
3.00	KV HEALTH CENTER	100.02	166,568			0	
TOTAL RECLASSIFICATIONS FOR CODE H			665,299	665,299			

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151324	FROM 1/ 1/2010	5/26/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: I
 EXPLANATION : IMPLANTABLE DEVICES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	IMPL. DEV. CHARGED TO PATIENT	55.30	67,889	OPERATING ROOM	37	67,889	
TOTAL RECLASSIFICATIONS FOR CODE I			67,889			67,889	

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES	PURCHASES	DONATION		AND		
		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	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES	PURCHASES	DONATION		AND		
		1	2	3	4	5	6	7
1	LAND	53,965					53,965	
2	LAND IMPROVEMENTS	1,844,495					1,844,495	
3	BUILDINGS & FIXTURE	9,331,820	5,576,824		5,576,824		14,908,644	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	798,894					798,894	
6	MOVABLE EQUIPMENT	4,808,019	146,801		146,801	461,399	4,493,421	
7	SUBTOTAL	16,837,193	5,723,625		5,723,625	461,399	22,099,419	
8	RECONCILING ITEMS							
9	TOTAL	16,837,193	5,723,625		5,723,625	461,399	22,099,419	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						OTHER CAPITAL RELATED COST	TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES			
	9	10	11	12	13	14	15	
* NEW CAP REL COSTS-BL	409,432			22,761			432,193	
5 TOTAL	409,432			22,761			432,193	

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						OTHER CAPITAL RELATED COST	TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES			
	9	10	11	12	13	14	15	
* NEW CAP REL COSTS-BL	423,807						423,807	
5 TOTAL	423,807						423,807	

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I 15-1324
I

I PERIOD: I PREPARED 5/26/2011
I FROM 1/ 1/2010 I WORKSHEET A-8
I TO 12/31/2010 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	LINE NO	
	1	2	COST CENTER 3	4	
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			**COST CENTER DELETED**	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	-831,452			
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 EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-11,359	MEDICAL RECORDS & LIBRARY	17	
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			**COST CENTER DELETED**	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 WELLNESS PROGRAM FEE	B	-4,013	PHYSICAL THERAPY	50	
38 MISCELLANEOUS INCOME INSURANCE	B	-19,759	NEW CAP REL COSTS-BLDG &	3	12
39 MISCELLANEOUS INCOME BENEFITS	B	-304,373	EMPLOYEE BENEFITS	5	
40 MISCELLANEOUS INCOME ADMIN	B	-444	ADMINISTRATIVE & GENERAL	6	
41 MISCELLANEOUS INCOME ADMIN	B	-361,046	ADMINISTRATIVE & GENERAL	6	
42 MISCELLANEOUS INCOME HOUSEKEEPING	B	-88	HOUSEKEEPING	10	
43 CAFETERIA GUEST	A	-66,634	CAFETERIA	12	
44 MISCELLANEOUS INCOME NURSING	B	-7,300	NURSING ADMINISTRATION	14	
45 MISCELLANEOUS INCOME PHARMACY	B	-101,797	PHARMACY	16	
46 MISCELLANEOUS INCOME MEDICAL RECORDS	B	-215	MEDICAL RECORDS & LIBRARY	17	
47 MISCELLANEOUS INCOME A&P	B	-520	ADULTS & PEDIATRICS	25	
48 MISCELLANEOUS SUPPLIES	B	-1,954	MEDICAL SUPPLIES CHARGED	55	
49 MISCELLANEOUS INCOME CLINIC	B	-11,829	WHEATFIELD CLINIC	63.50	
49.01 INTEREST INCOME	A	-2,845	ADMINISTRATIVE & GENERAL	6	
49.02 LOBBYING EXPENSE	A	-2,610	ADMINISTRATIVE & GENERAL	6	
49.03 GOODWILL AMORTIZATION	A	-14,375	NEW CAP REL COSTS-BLDG &	3	9
49.04 ANESTHESIA OFFSET	A	-32,500	ADULTS & PEDIATRICS	25	
49.05 ANESTHESIA OFFSET	A	-2,175	INTENSIVE CARE UNIT	26	
49.06 ANESTHESIA OFFSET	A	-384,475	OPERATING ROOM	37	
49.07 ANESTHESIA OFFSET	A	-675	RADIOLOGY-DIAGNOSTIC	41	
49.08 ANESTHESIA OFFSET	A	-75	LABORATORY	44	
49.09 ANESTHESIA OFFSET	A	-10,075	CLINIC	60	
49.10 ANESTHESIA OFFSET	A	-3,500	EMERGENCY	61	
49.11					
49.12					
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,176,088			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET A-8-2
 I I TO 12/31/2010 I GROUP 1

1	WKSHT A		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
2	LINE NO.		2	3	4	5	6	7	8	9
1	44	LAB		61,195		61,195				
2	61	ER		997,857	831,452	166,405				
3										
4										
5										
6										
7										
8										
9										
10										
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30										
101		TOTAL		1,059,052	831,452	227,600				

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

I PROVIDER NO: I 15-1324 I

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

I PREPARED 5/26/2011 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	780
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	5.51
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9		1555.00	235.00		
10		74.05	55.55		
11	37.03	37.03	27.78		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	115,148
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	13,054
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	128,202
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	128,202

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	128,202

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	28,883
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	28,883
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	4,298
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	33,181
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

REASONABLE COST DETERMINATION FOR THERAPY
 SERVICES FURNISHED BY OUTSIDE SUPPLIERS
 ON OR AFTER APRIL 10, 1998

PHYSICAL THERAPY

- 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
- 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
- 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE
 STANDARD TRAVEL EXPENSE

- 36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)
- 37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)
- 38 SUBTOTAL (SUM OF LINES 36 AND 37)
- 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)
- 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)
- 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)
- 42 SUBTOTAL (SUM OF LINES 40 AND 41)
- 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)
- TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
 COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
- 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)
- 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)
- 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)	1	2	3	4	5
48 OVERTIME RATE (SEE INSTRUCTIONS)					
CALCULATION OF LIMIT					
49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DETERMINATION OF OVERTIME ALLOWANCE					
52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO) (ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	128,202
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	128,202
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	114,678

PHYSICAL THERAPY

65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66 COST OF OUTSIDE SUPPLIER SERVICES - 114,678
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)

67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64) 114,678

68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000

68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)

68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)

69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	NOT ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	2	DOLLAR	VALUE	ENTERED
10	HOUSEKEEPING	3	HOURS OF	SERVICE	ENTERED
11	DIETARY	4	MEALS	SERVED	ENTERED
12	CAFETERIA	12	MAN	HOURS	ENTERED
14	NURSING ADMINISTRATION	10	MAN	HOURS	ENTERED
15	CENTRAL SERVICES & SUPPLY	6	100%	ALLOCATION	ENTERED
16	PHARMACY	7	100%	ALLOCATION	ENTERED
17	MEDICAL RECORDS & LIBRARY	8	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	9	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE
	0	3	5	5a.00	6	8	9
003 GENERAL SERVICE COST CNTR							
NEW CAP REL COSTS-BLDG &	432,193	432,193					
005 EMPLOYEE BENEFITS	4,461,019		4,461,019				
006 ADMINISTRATIVE & GENERAL	4,337,466	47,035	619,264	5,003,765	5,003,765		
008 OPERATION OF PLANT	638,156	9,377	62,020	709,553	128,201	837,754	
009 LAUNDRY & LINEN SERVICE	118,779	8,126	23,592	150,497	27,191	18,115	195,803
010 HOUSEKEEPING	542,930	7,915	114,971	665,816	120,298	17,645	
011 DIETARY	322,816	8,111	46,476	377,403	68,188	18,082	358
012 CAFETERIA	283,878	8,799	50,464	343,141	61,998	19,616	
014 NURSING ADMINISTRATION	347,791	4,442	91,512	443,745	80,175	9,903	
015 CENTRAL SERVICES & SUPPLY	-27,588		10,216	-17,372			
016 PHARMACY	2,402,078	4,397	101,869	2,508,344	453,203	9,803	
017 MEDICAL RECORDS & LIBRARY	410,636	4,095	93,898	508,629	91,898	9,130	
018 SOCIAL SERVICE	59,637	593	14,995	75,225	13,592	1,322	
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	2,064,694	78,367	502,150	2,645,211	477,916	174,709	66,142
026 INTENSIVE CARE UNIT	697,442	3,367	162,168	862,977	155,921	7,506	10,659
033 NURSERY	289,674	1,266	68,016	358,956	64,855	2,823	3,664
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	1,289,460	14,060	126,593	1,430,113	258,390	31,346	9,400
039 DELIVERY ROOM & LABOR ROO	50,056	2,563	11,753	64,372	11,631	5,713	635
041 RADIOLOGY-DIAGNOSTIC	2,355,372	16,055	263,800	2,635,227	476,128	35,793	7,896
044 LABORATORY	1,671,521	6,769	208,092	1,886,382	340,828	15,090	
047 BLOOD STORING, PROCESSING	154,377	588		154,965	27,999	1,311	
049 RESPIRATORY THERAPY	926,921	5,503	211,641	1,144,065	206,707	12,267	1,295
050 PHYSICAL THERAPY	682,949	8,231	139,852	831,032	150,149	18,350	17,321
050 01 KV HEALTH & DEMOTTE PT	611,224	43,312	138,342	792,878	143,256	96,558	
051 OCCUPATIONAL THERAPY	375,511	5,407	91,777	472,695	85,406	12,054	5,992
051 01 KV HEALTH & DEMOTTE OT	122,771	9,352	28,092	160,215	28,947	20,849	
052 SPEECH PATHOLOGY	123,220	1,774	30,116	155,110	28,025	3,955	1,919
052 01 KV HEALTH & DEMOTTE ST	92,569	7,050	21,181	120,800	21,826	15,718	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	244,914	5,035		249,949	45,160	11,225	
055 30 IMPL. DEV. CHARGED TO PAT	67,889			67,889	12,266		
056 DRUGS CHARGED TO PATIENTS							
OUTPAT SERVICE COST CNTRS							
060 CLINIC	715,109	8,673	165,762	889,544	160,721	19,336	13,698
061 EMERGENCY	1,201,573	8,251	230,201	1,440,025	260,181	18,395	16,236
062 OBSERVATION BEDS (NON-DIS							
063 FAMILY PRACTICE							
063 50 WHEATFIELD CLINIC	309,603		63,718	373,321	67,451		
063 53 BROOK RURAL HEALTH CENT	349,649	13,317	65,937	428,903	77,493	29,688	
OTHER REIMBURS COST CNTRS							
071 HOME HEALTH AGENCY	1,358,765	15,508	322,461	1,696,734	306,563	34,572	
SPEC PURPOSE COST CENTERS							
093 HOSPICE	432,464	1,251	19,618	453,333	81,907	2,790	
095 SUBTOTALS	30,517,518	358,589	4,100,547	30,083,442	4,534,470	673,664	155,215
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		1,156		1,156	209	2,577	
098 PHYSICIANS' PRIVATE OFFIC							
098 01 RENSSELAER HEALTH CENTER	-20			-20			
099 NONPAID WORKERS							
100 ALTERNACARE	531,853	49,327	132,685	713,865	128,980	109,968	40,588
100 01 DME EQUIPMENT	933,412	7,106	103,043	1,043,561	188,549	15,841	
100 02 KV HEALTH CENTER	339,504	12,935	80,280	432,719	78,183	28,836	
100 04 OTHER NONREIMBURSABLE COS	-38			-38			
100 05 MEALS ON WHEELS							
100 06 WATER LAB	76,922	1,598	15,178	93,698	16,929	3,563	
100 07 ADVERTISING	281,636	1,482	29,286	312,404	56,445	3,305	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	32,680,787	432,193	4,461,019	32,680,787	5,003,765	837,754	195,803

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR
	10	11	12	14	15	16	DS & LIBRARY
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
008 LAUNDRY & LINEN SERVICE							
009 HOUSEKEEPING	803,759						
010 DIETARY	2,866	466,897					
011 CAFETERIA	3,116		427,871				
012 NURSING ADMINISTRATION			10,148	543,971			
014 CENTRAL SERVICES & SUPPLY	4,034				-13,338		
015 PHARMACY	7,339		11,367			2,990,056	
016 MEDICAL RECORDS & LIBRARY	835		22,524				633,016
017 SOCIAL SERVICE	348		2,971				
018 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	365,840	187,546	84,531	205,872			237,318
026 INTENSIVE CARE UNIT	20,277	19,473	20,830	50,730			
033 NURSERY	3,137		8,401	20,459			4,736
037 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	14,016		14,641	35,657			50,355
041 DELIVERY ROOM & LABOR ROO	2,504		1,451	3,534			818
044 RADIOLOGY-DIAGNOSTIC	41,527		34,443	83,882			60,465
047 LABORATORY	27,859		35,567				12,728
049 BLOOD STORING, PROCESSING							
050 RESPIRATORY THERAPY	6,434		33,723				
051 PHYSICAL THERAPY	13,474		17,081				
052 01 KV HEALTH & DEMOTTE PT							
051 OCCUPATIONAL THERAPY	8,841		11,209				
051 01 KV HEALTH & DEMOTTE OT							
052 SPEECH PATHOLOGY	2,901		3,678				
052 01 KV HEALTH & DEMOTTE ST							
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED			3,772	9,187			
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS						2,990,056	
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC	31,997	3,640	21,024	51,201			169,458
062 EMERGENCY	54,917		34,265	83,449			97,138
062 OBSERVATION BEDS (NON-DIS							
063 FAMILY PRACTICE							
063 50 WHEATFIELD CLINIC							
063 53 BROOK RURAL HEALTH CENT							
071 OTHER REIMBURS COST CNTRS							
071 HOME HEALTH AGENCY	36,310						
093 SPEC PURPOSE COST CENTERS							
093 HOSPICE							
095 SUBTOTALS	648,572	210,659	371,626	543,971		2,990,056	633,016
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	2,365						
098 PHYSICIANS' PRIVATE OFFIC							
098 01 RENSSELAER HEALTH CENTER							
099 NONPAID WORKERS							
100 ALTERNACARE	131,328		30,492				
100 01 DME EQUIPMENT	18,155		18,386				
100 02 KV HEALTH CENTER		161,590					
100 04 OTHER NONREIMBURSABLE COS							
100 05 MEALS ON WHEELS		94,648					
100 06 WATER LAB	3,339			2,323			
100 07 ADVERTISING				5,044			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER					-13,338		
103 TOTAL	803,759	466,897	427,871	543,971		2,990,056	633,016

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	SOCIAL SERVIC SUBTOTAL		I&R COST POST STEP-DOWN ADJ 26	TOTAL
	18	25		
GENERAL SERVICE COST CNTR				27
003 NEW CAP REL COSTS-BLDG &				
005 EMPLOYEE BENEFITS				
006 ADMINISTRATIVE & GENERAL				
008 OPERATION OF PLANT				
009 LAUNDRY & LINEN SERVICE				
010 HOUSEKEEPING				
011 DIETARY				
012 CAFETERIA				
014 NURSING ADMINISTRATION				
015 CENTRAL SERVICES & SUPPLY				
016 PHARMACY				
017 MEDICAL RECORDS & LIBRARY				
018 SOCIAL SERVICE	93,458			
INPAT ROUTINE SRVC CNTRS				
025 ADULTS & PEDIATRICS	86,097	4,531,182		4,531,182
026 INTENSIVE CARE UNIT	7,361	1,155,734		1,155,734
033 NURSERY		467,031		467,031
ANCILLARY SRVC COST CNTRS				
037 OPERATING ROOM		1,843,918		1,843,918
039 DELIVERY ROOM & LABOR ROO		90,658		90,658
041 RADIOLOGY-DIAGNOSTIC		3,375,361		3,375,361
044 LABORATORY		2,318,454		2,318,454
047 BLOOD STORING, PROCESSING		184,275		184,275
049 RESPIRATORY THERAPY		1,404,491		1,404,491
050 PHYSICAL THERAPY		1,047,407		1,047,407
050 01 KV HEALTH & DEMOTTE PT		1,032,692		1,032,692
051 OCCUPATIONAL THERAPY		596,197		596,197
051 01 KV HEALTH & DEMOTTE OT		210,011		210,011
052 SPEECH PATHOLOGY		195,588		195,588
052 01 KV HEALTH & DEMOTTE ST		158,344		158,344
054 ELECTROENCEPHALOGRAPHY				
055 MEDICAL SUPPLIES CHARGED		319,293		319,293
055 30 IMPL. DEV. CHARGED TO PAT		80,155		80,155
056 DRUGS CHARGED TO PATIENTS		2,990,056		2,990,056
OUTPAT SERVICE COST CNTRS				
060 CLINIC		1,360,619		1,360,619
061 EMERGENCY		2,004,606		2,004,606
062 OBSERVATION BEDS (NON-DIS				
063 FAMILY PRACTICE				
063 50 WHEATFIELD CLINIC		440,772		440,772
063 53 BROOK RURAL HEALTH CENT		536,084		536,084
OTHER REIMBURS COST CNTRS				
071 HOME HEALTH AGENCY		2,074,179		2,074,179
SPEC PURPOSE COST CENTERS				
093 HOSPICE		538,030		538,030
095 SUBTOTALS	93,458	28,955,137		28,955,137
NONREIMBURS COST CENTERS				
096 GIFT, FLOWER, COFFEE SHOP		6,307		6,307
098 PHYSICIANS' PRIVATE OFFIC				
098 01 RENSSELAER HEALTH CENTER		-20		-20
099 NONPAID WORKERS				
100 ALTERNACARE		1,155,221		1,155,221
100 01 DME EQUIPMENT		1,284,492		1,284,492
100 02 KV HEALTH CENTER		701,328		701,328
100 04 OTHER NONREIMBURSABLE COS		-38		-38
100 05 MEALS ON WHEELS		94,648		94,648
100 06 WATER LAB		119,852		119,852
100 07 ADVERTISING		377,198		377,198
101 CROSS FOOT ADJUSTMENT				
102 NEGATIVE COST CENTER		-13,338		-13,338
103 TOTAL	93,458	32,680,787		32,680,787

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTs-BLDG &	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE
	0	3	4a	5	6	8	9
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		47,035	47,035		47,035		
008 OPERATION OF PLANT		9,377	9,377		1,205	10,582	
009 LAUNDRY & LINEN SERVICE		8,126	8,126		256	229	8,611
010 HOUSEKEEPING		7,915	7,915		1,131	223	
011 DIETARY		8,111	8,111		641	228	16
012 CAFETERIA		8,799	8,799		583	248	
014 NURSING ADMINISTRATION		4,442	4,442		753	125	
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY		4,397	4,397		4,259	124	
017 MEDICAL RECORDS & LIBRARY		4,095	4,095		864	115	
018 SOCIAL SERVICE		593	593		128	17	
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		78,367	78,367		4,502	2,205	2,909
026 INTENSIVE CARE UNIT		3,367	3,367		1,465	95	469
033 NURSERY		1,266	1,266		610	36	161
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		14,060	14,060		2,428	396	413
039 DELIVERY ROOM & LABOR ROO		2,563	2,563		109	72	28
041 RADIOLOGY-DIAGNOSTIC		16,055	16,055		4,475	452	347
044 LABORATORY		6,769	6,769		3,203	191	
047 BLOOD STORING, PROCESSING		588	588		263	17	
049 RESPIRATORY THERAPY		5,503	5,503		1,943	155	57
050 PHYSICAL THERAPY		8,231	8,231		1,411	232	762
050 01 KV HEALTH & DEMOTTE PT		43,312	43,312		1,346	1,220	
051 OCCUPATIONAL THERAPY		5,407	5,407		803	152	264
051 01 KV HEALTH & DEMOTTE OT		9,352	9,352		272	263	
052 SPEECH PATHOLOGY		1,774	1,774		263	50	84
052 01 KV HEALTH & DEMOTTE ST		7,050	7,050		205	199	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED		5,035	5,035		424	142	
055 30 IMPL. DEV. CHARGED TO PAT					115		
056 DRUGS CHARGED TO PATIENTS							
OUTPAT SERVICE COST CNTRS							
060 CLINIC		8,673	8,673		1,510	244	602
061 EMERGENCY		8,251	8,251		2,445	232	714
062 OBSERVATION BEDS (NON-DIS							
063 FAMILY PRACTICE							
063 50 WHEATFIELD CLINIC					634		
063 53 BROOK RURAL HEALTH CENT		13,317	13,317		728	375	
OTHER REIMBURS COST CNTRS							
071 HOME HEALTH AGENCY		15,508	15,508		2,881	437	
SPEC PURPOSE COST CENTERS							
093 HOSPICE		1,251	1,251		770	35	
095 SUBTOTALS		358,589	358,589		42,625	8,509	6,826
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		1,156	1,156		2	33	
098 PHYSICIANS' PRIVATE OFFIC							
098 01 RENSSELAER HEALTH CENTER							
099 NONPAID WORKERS							
100 ALTERNACARE		49,327	49,327		1,212	1,389	1,785
100 01 DME EQUIPMENT		7,106	7,106		1,772	200	
100 02 KV HEALTH CENTER		12,935	12,935		735	364	
100 04 OTHER NONREIMBURSABLE COS							
100 05 MEALS ON WHEELS							
100 06 WATER LAB		1,598	1,598		159	45	
100 07 ADVERTISING		1,482	1,482		530	42	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		432,193	432,193		47,035	10,582	8,611

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
	10	11	12	14	15	16	17
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	9,269						
011 DIETARY	33	9,029					
012 CAFETERIA	36		9,666				
014 NURSING ADMINISTRATION			229	5,549			
015 CENTRAL SERVICES & SUPPLY	47				47		
016 PHARMACY	85		257			9,122	
017 MEDICAL RECORDS & LIBRARY	10		509				5,593
018 SOCIAL SERVICE	4		67				
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,219	3,627	1,910	2,100			2,098
026 INTENSIVE CARE UNIT	234	377	471	517			
033 NURSERY	36		190	209			42
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM	162		331	364			445
039 DELIVERY ROOM & LABOR ROOM	29		33	36			7
041 RADIOLOGY-DIAGNOSTIC	479		778	856			534
044 LABORATORY	321		803				112
047 BLOOD STORING, PROCESSING							
049 RESPIRATORY THERAPY	74		762				
050 PHYSICAL THERAPY	155		386				
050 01 KV HEALTH & DEMOTTE PT OCCUPATIONAL THERAPY	102		253				
051 01 KV HEALTH & DEMOTTE OT SPEECH PATHOLOGY	33		83				
052 01 KV HEALTH & DEMOTTE ST ELECTROENCEPHALOGRAPHY			85	94			
054 MEDICAL SUPPLIES CHARGED							
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS						9,122	
060 CLINIC	369	70	475	522			1,497
061 EMERGENCY	633		774	851			858
062 OBSERVATION BEDS (NON-DIS)							
063 FAMILY PRACTICE							
063 50 WHEATFIELD CLINIC							
063 53 BROOK RURAL HEALTH CENT OTHER REIMBURS COST CNTRS							
071 HOME HEALTH AGENCY SPEC PURPOSE COST CENTERS	419						
093 HOSPICE							
095 SUBTOTALS	7,480	4,074	8,396	5,549		9,122	5,593
096 NONREIMBURS COST CENTERS GIFT, FLOWER, COFFEE SHOP	27						
098 PHYSICIANS' PRIVATE OFFICE							
098 01 RENSSELAER HEALTH CENTER							
099 NONPAID WORKERS							
100 ALTERNACARE	1,514		689				
100 01 DME EQUIPMENT	209		415				
100 02 KV HEALTH CENTER		3,125					
100 04 OTHER NONREIMBURSABLE COSTS							
100 05 MEALS ON WHEELS		1,830					
100 06 WATER LAB	39		52				
100 07 ADVERTISING			114				
101 CROSS FOOT ADJUSTMENTS						47	
102 NEGATIVE COST CENTER							
103 TOTAL	9,269	9,029	9,666	5,549	47	9,122	5,593

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET B
 I TO 12/31/2010 I PART III

	COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		18	25	26	27
003	GENERAL SERVICE COST CNTR				
005	NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS				
006	ADMINISTRATIVE & GENERAL OPERATION OF PLANT				
008	LAUNDRY & LINEN SERVICE				
010	HOUSEKEEPING				
011	DIETARY				
012	CAFETERIA				
014	NURSING ADMINISTRATION				
015	CENTRAL SERVICES & SUPPLY				
016	PHARMACY				
017	MEDICAL RECORDS & LIBRARY				
018	SOCIAL SERVICE	809			
	INPAT ROUTINE SRVC CNTRS				
025	ADULTS & PEDIATRICS	745	102,682		102,682
026	INTENSIVE CARE UNIT	64	7,059		7,059
033	NURSERY		2,550		2,550
	ANCILLARY SRVC COST CNTRS				
037	OPERATING ROOM		18,599		18,599
039	DELIVERY ROOM & LABOR ROO		2,877		2,877
041	RADIOLOGY-DIAGNOSTIC		23,976		23,976
044	LABORATORY		11,399		11,399
047	BLOOD STORING, PROCESSING		868		868
049	RESPIRATORY THERAPY		8,494		8,494
050	PHYSICAL THERAPY		11,177		11,177
050	01 KV HEALTH & DEMOTTE PT		45,878		45,878
051	OCCUPATIONAL THERAPY		6,981		6,981
051	01 KV HEALTH & DEMOTTE OT		9,887		9,887
052	SPEECH PATHOLOGY		2,287		2,287
052	01 KV HEALTH & DEMOTTE ST		7,454		7,454
054	ELECTROENCEPHALOGRAPHY				
055	MEDICAL SUPPLIES CHARGED		5,780		5,780
055	30 IMPL. DEV. CHARGED TO PAT		115		115
056	DRUGS CHARGED TO PATIENTS		9,122		9,122
	OUTPAT SERVICE COST CNTRS				
060	CLINIC		13,962		13,962
061	EMERGENCY		14,758		14,758
062	OBSERVATION BEDS (NON-DIS				
063	FAMILY PRACTICE				
063	50 WHEATFIELD CLINIC		634		634
063	53 BROOK RURAL HEALTH CENT		14,420		14,420
	OTHER REIMBURS COST CNTRS				
071	HOME HEALTH AGENCY		19,245		19,245
	SPEC PURPOSE COST CENTERS				
093	HOSPICE		2,056		2,056
095	SUBTOTALS	809	342,260		342,260
	NONREIMBURS COST CENTERS				
096	GIFT, FLOWER, COFFEE SHOP		1,218		1,218
098	PHYSICIANS' PRIVATE OFFIC				
098	01 RENSSELAER HEALTH CENTER				
099	NONPAID WORKERS				
100	ALTERNACARE		55,916		55,916
100	01 DME EQUIPMENT		9,702		9,702
100	02 KV HEALTH CENTER		17,159		17,159
100	04 OTHER NONREIMBURSABLE COS				
100	05 MEALS ON WHEELS		1,830		1,830
100	06 WATER LAB		1,893		1,893
100	07 ADVERTISING		2,168		2,168
101	CROSS FOOT ADJUSTMENTS				
102	NEGATIVE COST CENTER		47		47
103	TOTAL	809	432,193		432,193

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	NEW CAP REL C	EMPLOYEE BENE	RECONCIL- IATION	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE
	OSTS-BLDG & FEET	(GROSS) SALARIES		(ACCUM. COST	(SQUARE) FEET	(DOLLAR) VALUE
	3	5	6a.00	6	8	9
003 GENERAL SERVICE COST						
005 NEW CAP REL COSTS-BLD	86,006					
006 EMPLOYEE BENEFITS		17,129,407				
008 ADMINISTRATIVE & GENE	9,360	2,377,832	-5,003,765	27,694,452		
009 OPERATION OF PLANT	1,866	238,144		709,553	74,780	
010 LAUNDRY & LINEN SERVI	1,617	90,589		150,497	1,617	38,265
011 HOUSEKEEPING	1,575	441,466		665,816	1,575	
012 DIETARY	1,614	178,460		377,403	1,614	70
014 CAFETERIA	1,751	193,771		343,141	1,751	
015 NURSING ADMINISTRATIO	884	351,388		443,745	884	
016 CENTRAL SERVICES & SU		39,229	17,372			
017 PHARMACY	875	391,156		2,508,344	875	
018 MEDICAL RECORDS & LIB	815	360,551		508,629	815	
025 SOCIAL SERVICE	118	57,577		75,225	118	
026 INPAT ROUTINE SRVC CN						
033 ADULTS & PEDIATRICS	15,595	1,928,157		2,645,211	15,595	12,926
037 INTENSIVE CARE UNIT	670	622,693		862,977	670	2,083
039 NURSERY	252	261,169		358,956	252	716
041 ANCILLARY SRVC COST C						
044 OPERATING ROOM	2,798	486,092		1,430,113	2,798	1,837
047 DELIVERY ROOM & LABOR	510	45,130		64,372	510	124
049 RADIOLOGY-DIAGNOSTIC	3,195	1,012,942		2,635,227	3,195	1,543
050 LABORATORY	1,347	799,033		1,886,382	1,347	
051 BLOOD STORING, PROCES	117			154,965	117	
052 RESPIRATORY THERAPY	1,095	812,660		1,144,065	1,095	253
054 PHYSICAL THERAPY	1,638	537,003		831,032	1,638	3,385
055 01 KV HEALTH & DEMOTTE P	8,619	531,206		792,878	8,619	
056 OCCUPATIONAL THERAPY	1,076	352,404		472,695	1,076	1,171
060 01 KV HEALTH & DEMOTTE O	1,861	107,866		160,215	1,861	
063 SPEECH PATHOLOGY	353	115,638		155,110	353	375
066 01 KV HEALTH & DEMOTTE S	1,403	81,331		120,800	1,403	
069 ELECTROENCEPHALOGRAPH						
071 MEDICAL SUPPLIES CHAR	1,002			249,949	1,002	
074 30 IMPL. DEV. CHARGED TO				67,889		
077 DRUGS CHARGED TO PATI						
080 OUTPAT SERVICE COST C						
083 CLINIC	1,726	636,493		889,544	1,726	2,677
086 EMERGENCY	1,642	883,925		1,440,025	1,642	3,173
089 OBSERVATION BEDS (NON						
092 FAMILY PRACTICE						
095 50 WHEATFIELD CLINIC		244,664		373,321		
098 53 BROOK RURAL HEALTH CE	2,650	253,185		428,903	2,650	
101 OTHER REIMBURS COST C						
104 HOME HEALTH AGENCY	3,086	1,238,185		1,696,734	3,086	
107 SPEC PURPOSE COST CEN						
110 HOSPICE	249	75,330		453,333	249	
113 SUBTOTALS	71,359	15,745,269	-4,986,393	25,097,049	60,133	30,333
116 NONREIMBURS COST CENT						
119 GIFT, FLOWER, COFFEE	230			1,156	230	
122 PHYSICIANS' PRIVATE O						
125 01 RENSSELAER HEALTH CEN			20			
128 NONPAID WORKERS						
131 ALTERNACARE	9,816	509,485		713,865	9,816	7,932
134 01 DME EQUIPMENT	1,414	395,663		1,043,561	1,414	
137 02 KV HEALTH CENTER	2,574	308,259		432,719	2,574	
140 04 OTHER NONREIMBURSABLE			38			
143 05 MEALS ON WHEELS						
146 06 WATER LAB	318	58,280		93,698	318	
149 07 ADVERTISING	295	112,451		312,404	295	
152 CROSS FOOT ADJUSTMENT						
155 NEGATIVE COST CENTER						
158 COST TO BE ALLOCATED	432,193	4,461,019		5,003,765	837,754	195,803
161 (WRKSHT B, PART I)						
164 UNIT COST MULTIPLIER	5.025149	.260430		.180678	11.202915	5.117026
167 (WRKSHT B, PT I)						
170 COST TO BE ALLOCATED						
173 (WRKSHT B, PART II)						
176 UNIT COST MULTIPLIER						
179 (WRKSHT B, PT II)						
182 COST TO BE ALLOCATED				47,035	10,582	8,611
185 (WRKSHT B, PART III)						
188 UNIT COST MULTIPLIER				.001698	.141508	.225036
191 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)
	10	11	12	14	15	16	17
003 GENERAL SERVICE COST							
005 NEW CAP REL COSTS-BLD							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	115,550						
011 DIETARY	412	46,947					
012 CAFETERIA	448		418,111				
014 NURSING ADMINISTRATION			9,917	218,263			
015 CENTRAL SERVICES & SUPPLY	580				100		
016 PHARMACY	1,055		11,108			100	
017 MEDICAL RECORDS & LIBRARY	120		22,010				139,261
018 SOCIAL SERVICE	50		2,903				
025 INPAT ROUTINE SRVC CN ADULTS & PEDIATRICS	52,594	18,858	82,604	82,604			52,209
026 INTENSIVE CARE UNIT	2,915	1,958	20,355	20,355			
033 NURSERY	451		8,209	8,209			1,042
037 ANCILLARY SRVC COST CENTER OPERATING ROOM	2,015		14,307	14,307			11,078
039 DELIVERY ROOM & LABOR	360		1,418	1,418			180
041 RADIOLOGY-DIAGNOSTIC	5,970		33,657	33,657			13,302
044 LABORATORY	4,005		34,756				2,800
047 BLOOD STORING, PROCESSING							
049 RESPIRATORY THERAPY	925		32,954				
050 PHYSICAL THERAPY	1,937		16,691				
050 01 KV HEALTH & DEMOTTE PROGRAM OCCUPATIONAL THERAPY	1,271		10,953				
051 01 KV HEALTH & DEMOTTE PROGRAM SPEECH PATHOLOGY	417		3,594				
052 01 KV HEALTH & DEMOTTE PROGRAM ELECTROENCEPHALOGRAPHY							
054 MEDICAL SUPPLIES CHARGED TO PATIENTS			3,686	3,686	100		
055 30 IMPL. DEV. CHARGED TO PATIENTS						100	
056 OUTPAT SERVICE COST CENTER CLINIC	4,600	366	20,544	20,544			37,280
061 EMERGENCY	7,895		33,483	33,483			21,370
062 OBSERVATION BEDS (NON-REIMBURSABLE)							
063 50 FAMILY PRACTICE WHEATFIELD CLINIC							
063 53 BROOK RURAL HEALTH CENTER OTHER REIMBURS COST CENTER							
071 HOME HEALTH AGENCY SPEC PURPOSE COST CENTER	5,220						
093 HOSPICE							
095 SUBTOTALS	93,240	21,182	363,149	218,263	100	100	139,261
096 NONREIMBURS COST CENTER GIFT, FLOWER, COFFEE	340						
098 PHYSICIANS' PRIVATE OFFICE							
098 01 RENSSELAER HEALTH CENTER NONPAID WORKERS							
100 ALTERNACARE	18,880		29,796				
100 01 DME EQUIPMENT	2,610		17,967				
100 02 KV HEALTH CENTER		16,248					
100 04 OTHER NONREIMBURSABLE							
100 05 MEALS ON WHEELS		9,517					
100 06 WATER LAB	480		2,270				
100 07 ADVERTISING			4,929				
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED (WRKSHT B, PART I)	803,759	466,897	427,871	543,971	-13,338	2,990,056	633,016
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)	6.955941	9.945194	1.023343	2.492273		29,900.560000	4.545537
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)	9,269	9,029	9,666	5,549	47	9,122	5,593
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)	.080216	.192323	.023118	.025423		91.220000	.040162

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	SOCIAL SERVICE (TIME SPENT)
	18
003 GENERAL SERVICE COST	
005 NEW CAP REL COSTS-BLD	
006 EMPLOYEE BENEFITS	
008 ADMINISTRATIVE & GENE	
009 OPERATION OF PLANT	
010 LAUNDRY & LINEN SERVI	
011 HOUSEKEEPING	
012 DIETARY	
014 CAFETERIA	
015 NURSING ADMINISTRATIO	
016 CENTRAL SERVICES & SU	
017 PHARMACY	
018 MEDICAL RECORDS & LIB	419
025 SOCIAL SERVICE	
026 INPAT ROUTINE SRVC CN	
033 ADULTS & PEDIATRICS	386
037 INTENSIVE CARE UNIT	33
039 NURSERY	
041 ANCILLARY SRVC COST C	
044 OPERATING ROOM	
047 DELIVERY ROOM & LABOR	
049 RADIOLOGY-DIAGNOSTIC	
050 LABORATORY	
050 01 BLOOD STORING, PROCES	
051 01 RESPIRATORY THERAPY	
052 01 PHYSICAL THERAPY	
052 01 KV HEALTH & DEMOTTE P	
051 01 OCCUPATIONAL THERAPY	
052 01 KV HEALTH & DEMOTTE O	
054 01 SPEECH PATHOLOGY	
055 01 KV HEALTH & DEMOTTE S	
056 30 ELECTROENCEPHALOGRAPH	
060 30 MEDICAL SUPPLIES CHAR	
061 30 IMPL. DEV. CHARGED TO	
062 30 DRUGS CHARGED TO PATI	
063 30 OUTPAT SERVICE COST C	
063 50 CLINIC	
063 53 EMERGENCY	
071 50 OBSERVATION BEDS (NON	
093 53 FAMILY PRACTICE	
095 50 WHEATFIELD CLINIC	
096 53 BROOK RURAL HEALTH CE	
098 53 OTHER REIMBURS COST C	
099 01 HOME HEALTH AGENCY	
100 01 SPEC PURPOSE COST CEN	
100 01 HOSPICE	
100 01 SUBTOTALS	419
100 02 NONREIMBURS COST CENT	
100 04 GIFT, FLOWER, COFFEE	
100 05 PHYSICIANS' PRIVATE O	
100 06 RENSSELAER HEALTH CEN	
100 07 NONPAID WORKERS	
100 01 ALTERNACARE	
100 02 DME EQUIPMENT	
100 04 KV HEALTH CENTER	
100 05 OTHER NONREIMBURSABLE	
100 06 MEALS ON WHEELS	
100 07 WATER LAB	
100 07 ADVERTISING	
101 01 CROSS FOOT ADJUSTMENT	
102 01 NEGATIVE COST CENTER	
103 01 COST TO BE ALLOCATED	93,458
104 01 (PER WRKSHT B, PART	
105 01 UNIT COST MULTIPLIER	
106 01 (WRKSHT B, PT I)	223.050119
107 01 COST TO BE ALLOCATED	
108 01 (PER WRKSHT B, PART	
109 01 UNIT COST MULTIPLIER	
110 01 (WRKSHT B, PT II)	809
111 01 COST TO BE ALLOCATED	
112 01 (PER WRKSHT B, PART	
113 01 UNIT COST MULTIPLIER	
114 01 (WRKSHT B, PT III)	1.930788

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,531,182		4,531,182		4,531,182
26	INTENSIVE CARE UNIT	1,155,734		1,155,734		1,155,734
33	NURSERY	467,031		467,031		467,031
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,843,918		1,843,918		1,843,918
39	DELIVERY ROOM & LABOR ROO	90,658		90,658		90,658
41	RADIOLOGY-DIAGNOSTIC	3,375,361		3,375,361		3,375,361
44	LABORATORY	2,318,454		2,318,454		2,318,454
47	BLOOD STORING, PROCESSING	184,275		184,275		184,275
49	RESPIRATORY THERAPY	1,404,491		1,404,491		1,404,491
50	PHYSICAL THERAPY	1,047,407		1,047,407		1,047,407
50	01 KV HEALTH & DEMOTTE PT	1,032,692		1,032,692		1,032,692
51	OCCUPATIONAL THERAPY	596,197		596,197		596,197
51	01 KV HEALTH & DEMOTTE OT	210,011		210,011		210,011
52	SPEECH PATHOLOGY	195,588		195,588		195,588
52	01 KV HEALTH & DEMOTTE ST	158,344		158,344		158,344
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	319,293		319,293		319,293
55	30 IMPL. DEV. CHARGED TO PAT	80,155		80,155		80,155
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	2,990,056		2,990,056		2,990,056
60	CLINIC	1,360,619		1,360,619		1,360,619
61	EMERGENCY	2,004,606		2,004,606		2,004,606
62	OBSERVATION BEDS (NON-DIS	896,941		896,941		896,941
63	FAMILY PRACTICE					
63	50 WHEATFIELD CLINIC	440,772		440,772		440,772
63	53 BROOK RURAL HEALTH CENT OTHER REIMBURS COST CNTRS	536,084		536,084		536,084
101	SUBTOTAL	27,239,869		27,239,869		27,239,869
102	LESS OBSERVATION BEDS	896,941		896,941		896,941
103	TOTAL	26,342,928		26,342,928		26,342,928

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	3,498,729		3,498,729			
26	INTENSIVE CARE UNIT	573,800		573,800			
33	NURSERY	133,020		133,020			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,094,371	2,868,536	3,962,907	.465294	.465294	.465294
39	DELIVERY ROOM & LABOR ROO	133,984	64,108	198,092	.457656	.457656	.457656
41	RADIOLOGY-DIAGNOSTIC	772,817	6,037,760	6,810,577	.495606	.495606	.495606
44	LABORATORY	1,273,531	5,545,194	6,818,725	.340013	.340013	.340013
47	BLOOD STORING, PROCESSING	158,737	212,654	371,391	.496175	.496175	.496175
49	RESPIRATORY THERAPY	1,277,471	1,255,816	2,533,287	.554414	.554414	.554414
50	PHYSICAL THERAPY	223,162	1,246,916	1,470,078	.712484	.712484	.712484
50 01	KV HEALTH & DEMOTTE PT		1,268,056	1,268,056	.814390	.814390	.814390
51	OCCUPATIONAL THERAPY	175,802	328,900	504,702	1.181285	1.181285	1.181285
51 01	KV HEALTH & DEMOTTE OT		155,900	155,900	1.347088	1.347088	1.347088
52	SPEECH PATHOLOGY	38,617	122,872	161,489	1.211154	1.211154	1.211154
52 01	KV HEALTH & DEMOTTE ST		106,860	106,860	1.481789	1.481789	1.481789
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	263,260	816,621	1,079,881	.295674	.295674	.295674
55 30	IMPL. DEV. CHARGED TO PAT	63,295	140,372	203,667	.393559	.393559	.393559
56	DRUGS CHARGED TO PATIENTS	2,445,547	5,318,633	7,764,180	.385109	.385109	.385109
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	104,019	1,914,033	2,018,052	.674224	.674224	.674224
61	EMERGENCY	21,724	1,575,626	1,597,350	1.254957	1.254957	1.254957
62	OBSERVATION BEDS (NON-DIS	162,003	1,447,082	1,609,085	.557423	.557423	.557423
63	FAMILY PRACTICE						
63 50	WHEATFIELD CLINIC		349,512	349,512	1.261107	1.261107	1.261107
63 53	BROOK RURAL HEALTH CENT		349,113	349,113	1.535560	1.535560	1.535560
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	12,413,889	31,124,564	43,538,453			
102	LESS OBSERVATION BEDS						
103	TOTAL	12,413,889	31,124,564	43,538,453			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,531,182		4,531,182		4,531,182
26	INTENSIVE CARE UNIT	1,155,734		1,155,734		1,155,734
33	NURSERY	467,031		467,031		467,031
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,843,918		1,843,918		1,843,918
39	DELIVERY ROOM & LABOR ROO	90,658		90,658		90,658
41	RADIOLOGY-DIAGNOSTIC	3,375,361		3,375,361		3,375,361
44	LABORATORY	2,318,454		2,318,454		2,318,454
47	BLOOD STORING, PROCESSING	184,275		184,275		184,275
49	RESPIRATORY THERAPY	1,404,491		1,404,491		1,404,491
50	PHYSICAL THERAPY	1,047,407		1,047,407		1,047,407
50	01 KV HEALTH & DEMOTTE PT	1,032,692		1,032,692		1,032,692
51	OCCUPATIONAL THERAPY	596,197		596,197		596,197
51	01 KV HEALTH & DEMOTTE OT	210,011		210,011		210,011
52	SPEECH PATHOLOGY	195,588		195,588		195,588
52	01 KV HEALTH & DEMOTTE ST	158,344		158,344		158,344
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	319,293		319,293		319,293
55	30 IMPL. DEV. CHARGED TO PAT	80,155		80,155		80,155
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	2,990,056		2,990,056		2,990,056
60	CLINIC	1,360,619		1,360,619		1,360,619
61	EMERGENCY	2,004,606		2,004,606		2,004,606
62	OBSERVATION BEDS (NON-DIS	896,941		896,941		896,941
63	FAMILY PRACTICE					
63	50 WHEATFIELD CLINIC	440,772		440,772		440,772
63	53 BROOK RURAL HEALTH CENT OTHER REIMBURS COST CNTRS	536,084		536,084		536,084
101	SUBTOTAL	27,239,869		27,239,869		27,239,869
102	LESS OBSERVATION BEDS	896,941		896,941		896,941
103	TOTAL	26,342,928		26,342,928		26,342,928

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	3,498,729		3,498,729			
26	INTENSIVE CARE UNIT	573,800		573,800			
33	NURSERY	133,020		133,020			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,094,371	2,868,536	3,962,907	.465294	.465294	.465294
39	DELIVERY ROOM & LABOR ROO	133,984	64,108	198,092	.457656	.457656	.457656
41	RADIOLOGY-DIAGNOSTIC	772,817	6,037,760	6,810,577	.495606	.495606	.495606
44	LABORATORY	1,273,531	5,545,194	6,818,725	.340013	.340013	.340013
47	BLOOD STORING, PROCESSING	158,737	212,654	371,391	.496175	.496175	.496175
49	RESPIRATORY THERAPY	1,277,471	1,255,816	2,533,287	.554414	.554414	.554414
50	PHYSICAL THERAPY	223,162	1,246,916	1,470,078	.712484	.712484	.712484
50 01	KV HEALTH & DEMOTTE PT		1,268,056	1,268,056	.814390	.814390	.814390
51	OCCUPATIONAL THERAPY	175,802	328,900	504,702	1.181285	1.181285	1.181285
51 01	KV HEALTH & DEMOTTE OT		155,900	155,900	1.347088	1.347088	1.347088
52	SPEECH PATHOLOGY	38,617	122,872	161,489	1.211154	1.211154	1.211154
52 01	KV HEALTH & DEMOTTE ST		106,860	106,860	1.481789	1.481789	1.481789
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	263,260	816,621	1,079,881	.295674	.295674	.295674
55 30	IMPL. DEV. CHARGED TO PAT	63,295	140,372	203,667	.393559	.393559	.393559
56	DRUGS CHARGED TO PATIENTS	2,445,547	5,318,633	7,764,180	.385109	.385109	.385109
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	104,019	1,914,033	2,018,052	.674224	.674224	.674224
61	EMERGENCY	21,724	1,575,626	1,597,350	1.254957	1.254957	1.254957
62	OBSERVATION BEDS (NON-DIS	162,003	1,447,082	1,609,085	.557423	.557423	.557423
63	FAMILY PRACTICE						
63 50	WHEATFIELD CLINIC		349,512	349,512	1.261107	1.261107	1.261107
63 53	BROOK RURAL HEALTH CENT		349,113	349,113	1.535560	1.535560	1.535560
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	12,413,889	31,124,564	43,538,453			
102	LESS OBSERVATION BEDS						
103	TOTAL	12,413,889	31,124,564	43,538,453			

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
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,843,918	18,599	1,825,319			1,843,918
39	DELIVERY ROOM & LABOR ROO	90,658	2,877	87,781			90,658
41	RADIOLOGY-DIAGNOSTIC	3,375,361	23,976	3,351,385			3,375,361
44	LABORATORY	2,318,454	11,399	2,307,055			2,318,454
47	BLOOD STORING, PROCESSING	184,275	868	183,407			184,275
49	RESPIRATORY THERAPY	1,404,491	8,494	1,395,997			1,404,491
50	PHYSICAL THERAPY	1,047,407	11,177	1,036,230			1,047,407
50	01 KV HEALTH & DEMOTTE PT	1,032,692	45,878	986,814			1,032,692
51	OCCUPATIONAL THERAPY	596,197	6,981	589,216			596,197
51	01 KV HEALTH & DEMOTTE OT	210,011	9,887	200,124			210,011
52	SPEECH PATHOLOGY	195,588	2,287	193,301			195,588
52	01 KV HEALTH & DEMOTTE ST	158,344	7,454	150,890			158,344
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	319,293	5,780	313,513			319,293
55	30 IMPL. DEV. CHARGED TO PAT	80,155	115	80,040			80,155
56	DRUGS CHARGED TO PATIENTS	2,990,056	9,122	2,980,934			2,990,056
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	1,360,619	13,962	1,346,657			1,360,619
61	EMERGENCY	2,004,606	14,758	1,989,848			2,004,606
62	OBSERVATION BEDS (NON-DIS	896,941		896,941			896,941
63	FAMILY PRACTICE						
63	50 WHEATFIELD CLINIC	440,772	634	440,138			440,772
63	53 BROOK RURAL HEALTH CENT	536,084	14,420	521,664			536,084
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	21,085,922	208,668	20,877,254			21,085,922
102	LESS OBSERVATION BEDS	896,941		896,941			896,941
103	TOTAL	20,188,981	208,668	19,980,313			20,188,981

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	3,962,907	.465294	.465294
39	DELIVERY ROOM & LABOR ROO	198,092	.457656	.457656
41	RADIOLOGY-DIAGNOSTIC	6,810,577	.495606	.495606
44	LABORATORY	6,818,725	.340013	.340013
47	BLOOD STORING, PROCESSING	371,391	.496175	.496175
49	RESPIRATORY THERAPY	2,533,287	.554414	.554414
50	PHYSICAL THERAPY	1,470,078	.712484	.712484
50	01 KV HEALTH & DEMOTTE PT	1,268,056	.814390	.814390
51	OCCUPATIONAL THERAPY	504,702	1.181285	1.181285
51	01 KV HEALTH & DEMOTTE OT	155,900	1.347088	1.347088
52	SPEECH PATHOLOGY	161,489	1.211154	1.211154
52	01 KV HEALTH & DEMOTTE ST	106,860	1.481789	1.481789
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,079,881	.295674	.295674
55	30 IMPL. DEV. CHARGED TO PAT	203,667	.393559	.393559
56	DRUGS CHARGED TO PATIENTS	7,764,180	.385109	.385109
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	2,018,052	.674224	.674224
61	EMERGENCY	1,597,350	1.254957	1.254957
62	OBSERVATION BEDS (NON-DIS	1,609,085	.557423	.557423
63	FAMILY PRACTICE			
63	50 WHEATFIELD CLINIC	349,512	1.261107	1.261107
63	53 BROOK RURAL HEALTH CENT	349,113	1.535560	1.535560
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	39,332,904		
102	LESS OBSERVATION BEDS	1,609,085		
103	TOTAL	37,723,819		

Health Financial Systems MCRIF32 FOR JASPER COUNTY HOSPITAL
 CALCULATION OF OUTPATIENT SERVICE COST TO
 CHARGE RATIOS NET OF REDUCTIONS
 SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART II

**NOT A CMS WORKSHEET ** (09/2000)

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
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,843,918	18,599	1,825,319			1,843,918
39	DELIVERY ROOM & LABOR ROO	90,658	2,877	87,781			90,658
41	RADIOLOGY-DIAGNOSTIC	3,375,361	23,976	3,351,385			3,375,361
44	LABORATORY	2,318,454	11,399	2,307,055			2,318,454
47	BLOOD STORING, PROCESSING	184,275	868	183,407			184,275
49	RESPIRATORY THERAPY	1,404,491	8,494	1,395,997			1,404,491
50	PHYSICAL THERAPY	1,047,407	11,177	1,036,230			1,047,407
50 01	KV HEALTH & DEMOTTE PT	1,032,692	45,878	986,814			1,032,692
51	OCCUPATIONAL THERAPY	596,197	6,981	589,216			596,197
51 01	KV HEALTH & DEMOTTE OT	210,011	9,887	200,124			210,011
52	SPEECH PATHOLOGY	195,588	2,287	193,301			195,588
52 01	KV HEALTH & DEMOTTE ST	158,344	7,454	150,890			158,344
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	319,293	5,780	313,513			319,293
55 30	IMPL. DEV. CHARGED TO PAT	80,155	115	80,040			80,155
56	DRUGS CHARGED TO PATIENTS	2,990,056	9,122	2,980,934			2,990,056
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	1,360,619	13,962	1,346,657			1,360,619
61	EMERGENCY	2,004,606	14,758	1,989,848			2,004,606
62	OBSERVATION BEDS (NON-DIS	896,941		896,941			896,941
63	FAMILY PRACTICE						
63 50	WHEATFIELD CLINIC	440,772	634	440,138			440,772
63 53	BROOK RURAL HEALTH CENT	536,084	14,420	521,664			536,084
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	21,085,922	208,668	20,877,254			21,085,922
102	LESS OBSERVATION BEDS	896,941		896,941			896,941
103	TOTAL	20,188,981	208,668	19,980,313			20,188,981

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS	3,962,907	.465294	.465294
39	OPERATING ROOM	198,092	.457656	.457656
41	DELIVERY ROOM & LABOR ROO	6,810,577	.495606	.495606
44	RADIOLOGY-DIAGNOSTIC	6,818,725	.340013	.340013
47	LABORATORY	371,391	.496175	.496175
49	BLOOD STORING, PROCESSING	2,533,287	.554414	.554414
50	RESPIRATORY THERAPY	1,470,078	.712484	.712484
50	PHYSICAL THERAPY	1,268,056	.814390	.814390
51	01 KV HEALTH & DEMOTTE PT	504,702	1.181285	1.181285
51	OCCUPATIONAL THERAPY	155,900	1.347088	1.347088
52	01 KV HEALTH & DEMOTTE OT	161,489	1.211154	1.211154
52	SPEECH PATHOLOGY	106,860	1.481789	1.481789
54	01 KV HEALTH & DEMOTTE ST			
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	1,079,881	.295674	.295674
55	30 IMPL. DEV. CHARGED TO PAT	203,667	.393559	.393559
56	DRUGS CHARGED TO PATIENTS	7,764,180	.385109	.385109
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	2,018,052	.674224	.674224
61	EMERGENCY	1,597,350	1.254957	1.254957
62	OBSERVATION BEDS (NON-DIS	1,609,085	.557423	.557423
63	FAMILY PRACTICE			
63	50 WHEATFIELD CLINIC	349,512	1.261107	1.261107
63	53 BROOK RURAL HEALTH CENT	349,113	1.535560	1.535560
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	39,332,904		
102	LESS OBSERVATION BEDS	1,609,085		
103	TOTAL	37,723,819		

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge	Cost/Charge	Cost/Charge	Outpatient	Outpatient
	Ratio (C, Pt I, col. 9)	Ratio (C, Pt I, col. 9)	Ratio (C, Pt II, col. 9)	Ambulatory Surgical Ctr	Radialogy
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.465294		.465294		
39 DELIVERY ROOM & LABOR ROOM	.457656		.457656		
41 RADIOLOGY-DIAGNOSTIC	.495606		.495606		
44 LABORATORY	.340013		.340013		
47 BLOOD STORING, PROCESSING & TRANS.	.496175		.496175		
49 RESPIRATORY THERAPY	.554414		.554414		
50 PHYSICAL THERAPY	.712484		.712484		
50 01 KV HEALTH & DEMOTTE PT	.814390		.814390		
51 OCCUPATIONAL THERAPY	1.181285		1.181285		
51 01 KV HEALTH & DEMOTTE OT	1.347088		1.347088		
52 SPEECH PATHOLOGY	1.211154		1.211154		
52 01 KV HEALTH & DEMOTTE ST	1.481789		1.481789		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.295674		.295674		
55 30 IMPL. DEV. CHARGED TO PATIENT	.393559		.393559		
56 DRUGS CHARGED TO PATIENTS	.385109		.385109		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	.674224		.674224		
61 EMERGENCY	1.254957		1.254957		
62 OBSERVATION BEDS (NON-DISTINCT PART)	.557423		.557423		
63 FAMILY PRACTICE					
63 50 WHEATFIELD CLINIC					
63 53 BROOK RURAL HEALTH CENT					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		867,424			
39 DELIVERY ROOM & LABOR ROOM		1,695			
41 RADIOLOGY-DIAGNOSTIC		1,828,707			
44 LABORATORY		1,963,761			
47 BLOOD STORING, PROCESSING & TRANS.		102,498			
49 RESPIRATORY THERAPY		455,463			
50 PHYSICAL THERAPY		346,243			
50 01 KV HEALTH & DEMOTTE PT		303,567			
51 OCCUPATIONAL THERAPY		77,983			
51 01 KV HEALTH & DEMOTTE OT		29,239			
52 SPEECH PATHOLOGY		14,363			
52 01 KV HEALTH & DEMOTTE ST		2,442			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		254,867			
55 30 IMPL. DEV. CHARGED TO PATIENT		60,221			
56 DRUGS CHARGED TO PATIENTS		2,591,212			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		892,468			
61 EMERGENCY		488,294			
62 OBSERVATION BEDS (NON-DISTINCT PART)		608,769			
63 FAMILY PRACTICE					
63 50 WHEATFIELD CLINIC					
63 53 BROOK RURAL HEALTH CENT					
101 SUBTOTAL		10,889,216			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		10,889,216			

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2010 I PART V
 I 15-1324 I I

TITLE XVIII, PART B

HOSPITAL

All Other Hospital I/P Hospital I/P
 Part B Charges Part B Costs

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	403,607		
39 DELIVERY ROOM & LABOR ROOM	776		
41 RADIOLOGY-DIAGNOSTIC	906,318		
44 LABORATORY	667,704		
47 BLOOD STORING, PROCESSING & TRANS.	50,857		
49 RESPIRATORY THERAPY	252,515		
50 PHYSICAL THERAPY	246,693		
50 01 KV HEALTH & DEMOTTE PT	247,222		
51 OCCUPATIONAL THERAPY	92,120		
51 01 KV HEALTH & DEMOTTE OT	39,388		
52 SPEECH PATHOLOGY	17,396		
52 01 KV HEALTH & DEMOTTE ST	3,619		
54 ELECTROENCEPHALOGRAPHY			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	75,358		
55 30 IMPL. DEV. CHARGED TO PATIENT	23,701		
56 DRUGS CHARGED TO PATIENTS	997,899		
OUTPAT SERVICE COST CNTRS			
60 CLINIC	601,723		
61 EMERGENCY	612,788		
62 OBSERVATION BEDS (NON-DISTINCT PART)	339,342		
63 FAMILY PRACTICE			
63 50 WHEATFIELD CLINIC			
63 53 BROOK RURAL HEALTH CENT			
101 SUBTOTAL	5,579,026		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	5,579,026		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,245
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,834
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,834
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,259
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	152
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)	2,412
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,259
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	145.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,531,182
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	22,040
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	953,763
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,577,419

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4,205,549
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,205,549
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.850643
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	869.99
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,577,419

TITLE XVIII PART A 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 740.05
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,785,001
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,785,001

	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	1,155,734	379	3,049.43	330	1,006,312
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1 2,068,184
49 TOTAL PROGRAM INPATIENT COSTS					4,859,497

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) 931,723
 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 931,723
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
 COST REPORTING PERIOD
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
 COST REPORTING PERIOD
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I 15-1324 I I

TITLE XVIII PART A HOSPITAL OTHER

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS 1,212
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 740.05
- 85 OBSERVATION BED COST 896,941

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					

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)	6,245
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,834
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,834
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)	1,259
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)	152
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	167
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)	231
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,531,182
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)	936,281
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,594,901

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4,205,549
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,205,549
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.854799
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	869.99
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,594,901

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					743.67
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					124,193
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					124,193

	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	467,031	231	2,021.78	
43	INTENSIVE CARE UNIT	1,155,734	379	3,049.43	
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				169,363
49	TOTAL PROGRAM INPATIENT COSTS				293,556

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

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I 15-1324 I I

TITLE XIX - I/P HOSPITAL OTHER

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

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

1

PART IV - COMPUTATION OF OBSERVATION BED COST

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

1,212
 743.67
 901,328

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1324 I

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,782,752	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		429,000	
37	OPERATING ROOM	.465294	389,779	181,362
39	DELIVERY ROOM & LABOR ROOM	.457656		
41	RADIOLOGY-DIAGNOSTIC	.495606	559,189	277,137
44	LABORATORY	.340013	784,683	266,802
47	BLOOD STORING, PROCESSING & TRANS.	.496175	114,380	56,752
49	RESPIRATORY THERAPY	.554414	859,870	476,724
50	PHYSICAL THERAPY	.712484	98,078	69,879
50 01	KV HEALTH & DEMOTTE PT	.814390		
51	OCCUPATIONAL THERAPY	1.181285	59,740	70,570
51 01	KV HEALTH & DEMOTTE OT	1.347088		
52	SPEECH PATHOLOGY	1.211154	23,975	29,037
52 01	KV HEALTH & DEMOTTE ST	1.481789		
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.295674	147,405	43,584
55 30	IMPL. DEV. CHARGED TO PATIENT	.393559	44,170	17,384
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.385109	1,376,433	530,077
60	CLINIC	.674224	67,734	45,668
61	EMERGENCY	1.254957	2,556	3,208
62	OBSERVATION BEDS (NON-DISTINCT PART)	.557423		
63	FAMILY PRACTICE			
63 50	WHEATFIELD CLINIC			
63 53	BROOK RURAL HEALTH CENT			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		4,527,992	2,068,184
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		4,527,992	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-Z324 I I

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.465294	10,245	4,767
39	DELIVERY ROOM & LABOR ROOM	.457656		
41	RADIOLOGY-DIAGNOSTIC	.495606	28,850	14,298
44	LABORATORY	.340013	117,385	39,912
47	BLOOD STORING, PROCESSING & TRANS.	.496175	5,151	2,556
49	RESPIRATORY THERAPY	.554414	222,432	123,319
50	PHYSICAL THERAPY	.712484	89,625	63,856
50 01	KV HEALTH & DEMOTTE PT	.814390		
51	OCCUPATIONAL THERAPY	1.181285	90,101	106,435
51 01	KV HEALTH & DEMOTTE OT	1.347088		
52	SPEECH PATHOLOGY	1.211154	11,422	13,834
52 01	KV HEALTH & DEMOTTE ST	1.481789		
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.295674	5,762	1,704
55 30	IMPL. DEV. CHARGED TO PATIENT	.393559		
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.385109	344,237	132,569
60	CLINIC	.674224	2,073	1,398
61	EMERGENCY	1.254957		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.557423		
63	FAMILY PRACTICE			
63 50	WHEATFIELD CLINIC			
63 53	BROOK RURAL HEALTH CENT			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		927,283	504,648
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		927,283	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1324 I I

TITLE XIX

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		111,635	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		8,419	
37	OPERATING ROOM	.465294	92,984	43,265
39	DELIVERY ROOM & LABOR ROOM	.457656	43,713	20,006
41	RADIOLOGY-DIAGNOSTIC	.495606	22,931	11,365
44	LABORATORY	.340013	44,565	15,153
47	BLOOD STORING, PROCESSING & TRANS.	.496175	5,500	2,729
49	RESPIRATORY THERAPY	.554414	23,564	13,064
50	PHYSICAL THERAPY	.712484	2,030	1,446
50 01	KV HEALTH & DEMOTTE PT	.814390		
51	OCCUPATIONAL THERAPY	1.181285		
51 01	KV HEALTH & DEMOTTE OT	1.347088		
52	SPEECH PATHOLOGY	1.211154		
52 01	KV HEALTH & DEMOTTE ST	1.481789		
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.295674	17,015	5,031
55 30	IMPL. DEV. CHARGED TO PATIENT	.393559		
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.385109	69,605	26,806
60	CLINIC	.674224	3,866	2,607
61	EMERGENCY	1.254957	7,982	10,017
62	OBSERVATION BEDS (NON-DISTINCT PART)	.557423	32,065	17,874
63	FAMILY PRACTICE			
63 50	WHEATFIELD CLINIC	1.261107		
63 53	BROOK RURAL HEALTH CENT	1.535560		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		365,820	169,363
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		365,820	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET E
 I COMPONENT NO: I TO 12/31/2010 I PART B
 I 15-1324 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 5,579,026
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1,
 2001 (SEE INSTRUCTIONS).
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.
 1.04 LINE 1.01 TIMES LINE 1.03.
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)
 1.07 OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV
 (COLS 9, 9.01, 9.02) LINE 101
 2 INTERNS AND RESIDENTS
 3 ORGAN ACQUISITIONS
 4 COST OF TEACHING PHYSICIANS
 5 TOTAL COST (SEE INSTRUCTIONS) 5,579,026

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES
 6 ANCILLARY SERVICE CHARGES
 7 INTERNS AND RESIDENTS SERVICE CHARGES
 8 ORGAN ACQUISITION CHARGES
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.
 10 TOTAL REASONABLE CHARGES
 CUSTOMARY CHARGES
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR
 PAYMENT FOR SERVICES ON A CHARGE BASIS
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT
 BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).
 13 RATIO OF LINE 11 TO LINE 12
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 5,634,816
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 35,565
 18.01 CAH ACTUAL BILLED COINSURANCE 1,771,130
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 3,828,121
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
 22 ESRD DIRECT MEDICAL EDUCATION COSTS
 23 SUBTOTAL 3,828,121
 24 PRIMARY PAYER PAYMENTS 1,421
 25 SUBTOTAL 3,826,700

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 284,690
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 284,690
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 220,183
 28 SUBTOTAL 4,111,390
 29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER
 TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.
 30 OTHER ADJUSTMENTS (SPECIFY)
 30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)
 31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING
 FROM DISPOSITION OF DEPRECIABLE ASSETS.
 32 SUBTOTAL 4,111,390
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 3,637,988
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 35 BALANCE DUE PROVIDER/PROGRAM 473,402
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

TO BE COMPLETED BY CONTRACTOR

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-1324 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,684,908		3,639,110
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	8/ 5/2010	141,333		
ADJUSTMENTS TO PROVIDER .02	12/23/2010	122,571		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50			12/23/2010	1,122
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		263,904		-1,122
4 TOTAL INTERIM PAYMENTS		3,948,812		3,637,988
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		531,176		473,402
AMOUNT (BALANCE DUE)				
BASED ON COST REPORT (1)				
7 TOTAL MEDICARE PROGRAM LIABILITY		4,479,988		4,111,390

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-Z324 I I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,303,205		
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	8/ 5/2010	21,607		
ADJUSTMENTS TO PROVIDER .02	12/23/2010	22,468		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		44,075		NONE
4 TOTAL INTERIM PAYMENTS		1,347,280		
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)		101,391		
7 TOTAL MEDICARE PROGRAM LIABILITY		1,448,671		

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I
 I COMPONENT NO: I TO 12/31/2010 I WORKSHEET E-2
 I 15-Z324 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	941,040	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	509,694	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	1,259	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,450,734	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,450,734	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,450,734	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	2,063	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,448,671	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,448,671	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,347,280	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	101,391	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2010 I PART II
 I 15-1324 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	4,859,497
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	4,859,497
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	4,908,092
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	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)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	4,908,092
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	490,143
21	EXCESS REASONABLE COST	
22	SUBTOTAL	4,417,949
23	COINSURANCE	
24	SUBTOTAL	4,417,949
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	62,039
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	62,039
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	50,483
26	SUBTOTAL	4,479,988
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	4,479,988
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,948,812
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	531,176
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2010 I PART III
 I - I I

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		293,556	
2	MEDICAL AND OTHER SERVICES			
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
6	SUBTOTAL		293,556	
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL		293,556	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES		120,087	
11	ANCILLARY SERVICE CHARGES		365,820	
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		485,907	
	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)		485,907	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		192,351	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES		293,556	
	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		293,556	
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		293,556	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL		293,556	
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)		293,556	
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		293,556	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		293,556	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS		136,843	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
58	BALANCE DUE PROVIDER/PROGRAM		156,713	
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			

Health Financial Systems MCRIF32 FOR JASPER COUNTY HOSPITAL

CALCULATION OF REIMBURSEMENT SETTLEMENT

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

TITLE XIX

HOSPITAL

OTHER
TITLE V OR
TITLE XIX

TITLE XVIII
SNF PPS

1

2

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

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

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/26/2011
I	15-1324	I	FROM 1/ 1/2010	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2010	I	PART III
I	-	I		I	

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I
 I TO 12/31/2010 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	2,280,695			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	5,311,349			
5 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY	1,239,307			
8 PREPAID EXPENSES				
9 OTHER CURRENT ASSETS				
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	8,831,351			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS				
13 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	12,834,686			
14.01 LESS ACCUMULATED DEPRECIATION				
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				
18.01 LESS ACCUMULATED DEPRECIATION				
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	12,834,686			
OTHER ASSETS				
22 INVESTMENTS	2,569,857			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	380,937			
26 TOTAL OTHER ASSETS	2,950,794			
27 TOTAL ASSETS	24,616,831			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I
 I I TO 12/31/2010 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	2,627,073			
29 SALARIES, WAGES & FEES PAYABLE				
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	1,015,686			
36 TOTAL CURRENT LIABILITIES	3,642,759			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	6,168,245			
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	6,168,245			
43 TOTAL LIABILITIES	9,811,004			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	14,805,827			
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	14,805,827			
52 TOTAL LIABILITIES AND FUND BALANCES	24,616,831			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		17,490,196		
2 NET INCOME (LOSS)		-2,684,370		
3 TOTAL		14,805,826		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9	1			
10 TOTAL ADDITIONS		1		
11 SUBTOTAL		14,805,827		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		14,805,827		

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET G-2
 I I TO 12/31/2010 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	3,594,026		3,594,026
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,594,026		3,594,026
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	576,400		576,400
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	576,400		576,400
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	4,170,426		4,170,426
17 00 ANCILLARY SERVICES	8,932,769	29,146,912	38,079,681
18 00 OUTPATIENT SERVICES		4,801,813	4,801,813
18 50 WHEATFIELD CLINIC		349,512	349,512
18 53 BROOK RURAL HEALTH CENT		349,113	349,113
19 00 HOME HEALTH AGENCY		2,543,413	2,543,413
23 00 HOSPICE			
24 00			
25 00 TOTAL PATIENT REVENUES	13,103,195	37,190,763	50,293,958

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES	34,856,875
ADD (SPECIFY)	
27 00 ADD (SPECIFY)	
28 00	
29 00	
30 00	
31 00	
32 00	
33 00 TOTAL ADDITIONS	
DEDUCT (SPECIFY)	
34 00 DEDUCT (SPECIFY)	
35 00	
36 00	
37 00	
38 00	
39 00 TOTAL DEDUCTIONS	
40 00 TOTAL OPERATING EXPENSES	34,856,875

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET G-3
 I I TO 12/31/2010 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	50,293,958
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	22,176,851
3	NET PATIENT REVENUES	28,117,107
4	LESS: TOTAL OPERATING EXPENSES	34,856,875
5	NET INCOME FROM SERVICE TO PATIENTS	-6,739,768
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER REVENUE	4,050,914
24.01	GRANTS	152,988
24.02	INVESTMENT INCOME	23,644
25	TOTAL OTHER INCOME	4,227,546
26	TOTAL	-2,512,222
	OTHER EXPENSES	
27	OTHER EXPENSES	172,148
28		
29		
30	TOTAL OTHER EXPENSES	172,148
31	NET INCOME (OR LOSS) FOR THE PERIOD	-2,684,370

HHA 1

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPORTATION 3	CONTRACTED/ PURCHASED SVCS 4	OTHER COSTS 5	TOTAL 6
GENERAL SERVICE COST CENTERS						
1						
2						
3						
4						
5	348,460				361,302	709,762
HHA REIMBURSABLE SERVICES						
6	577,969					577,969
7						
8						
9						
10	4,862					4,862
11	233,961					233,961
12						
13						
13.20						
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22						
23						
23.50						
24	1,165,252				361,302	1,526,554

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4				
5	-167,789	541,973		541,973
HHA REIMBURSABLE SERVICES				
6		577,969		577,969
7				
8				
9				
10		4,862		4,862
11		233,961		233,961
12				
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22				
23				
23.50				
24	-167,789	1,358,765		1,358,765

HHA 1

	NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
	0	1	2	3	4	4A	5
GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5	541,973					541,973	541,973
HHA REIMBURSABLE SERVICES							
6	577,969					577,969	383,505
7							
8							
9							
10	4,862					4,862	3,226
11	233,961					233,961	155,242
12							
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	1,358,765					1,358,765	
TOTAL (SUM OF LINES 1-23)							

TOTAL

6

GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
HHA REIMBURSABLE SERVICES							
6	961,474						
7							
8							
9							
10	8,088						
11	389,203						
12							
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	1,358,765						
TOTAL (SUM OF LINES 1-23)							

HHA 1

	CAP-REL COST-BLDG & FIX (SQUARE FEET)	CAP-REL COST-MOV EQUIP (DOLLAR VALUE)	PLANT OPER & MAINT (SQUARE FEET)	TRANSPORTATIO N (MILEAGE)	RECONCILIATIO N ()	ADMINISTRATIV E & GENERAL (ACCUM. COST)
	1	2	3	4	5A	5
GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX					
2	CAP-REL COST-MOV EQUIP					
3	PLANT OPER & MAINT					
4	TRANSPORTATION					
5	ADMINISTRATIVE & GENERAL				-541,973	816,792
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE					577,969
7	PHYSICAL THERAPY					
8	OCCUPATIONAL THERAPY					
9	SPEECH PATHOLOGY					
10	MEDICAL SOCIAL SERVICES					4,862
11	HOME HEALTH AIDE					233,961
12	SUPPLIES					
13	DRUGS					
13.20	COST ADMINISTERING DRUGS					
14	DME					
HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS					
16	RESPIRATORY THERAPY					
17	PRIVATE DUTY NURSING					
18	CLINIC					
19	HEALTH PROM ACTIVITIES					
20	DAY CARE PROGRAM					
21	HOME DEL MEALS PROGRAM					
22	HOMEMAKER SERVICE					
23	ALL OTHERS					
23.50	TELEMEDICINE					
24	TOTAL (SUM OF LINES 1-23)				-541,973	816,792
25	COST TO BE ALLOCATED					541,973
26	UNIT COST MULTIPLIER					.663539

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A	ADMINISTRATI VE & GENERAL 6	OPERATION OF PLANT 8
1 ADMIN & GENERAL		15,508	322,461	337,969	61,064	34,572
2 SKILLED NURSING CARE	961,474			961,474	173,718	
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES	8,088			8,088	1,461	
7 HOME HEALTH AIDE	389,203			389,203	70,320	
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	1,358,765	15,508	322,461	1,696,734	306,563	34,572
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMI NISTRATION 14	CENTRAL SERV ICES & SUPPL 15
1 ADMIN & GENERAL		36,310				
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)		36,310				
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	PHARMACY	MEDICAL RECO RDS & LIBRAR	SOCIAL SERVI CE	SUBTOTAL	POST STEP DOWN ADJUST	SUBTOTAL
	16	17	18	25	26	27
1 ADMIN & GENERAL				469,915		469,915
2 SKILLED NURSING CARE				1,135,192		1,135,192
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES				9,549		9,549
7 HOME HEALTH AIDE				459,523		459,523
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)				2,074,179		2,074,179
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1 ADMIN & GENERAL		
2 SKILLED NURSING CARE	332,516	1,467,708
3 PHYSICAL THERAPY		
4 OCCUPATIONAL THERAPY		
5 SPEECH PATHOLOGY		
6 MEDICAL SOCIAL SERVICES	2,797	12,346
7 HOME HEALTH AIDE	134,602	594,125
8 SUPPLIES		
9 DRUGS		
9.20 COST ADMINISTERING DRUGS		
10 DME		
11 HOME DIALYSIS AIDE SVCS		
12 RESPIRATORY THERAPY		
13 PRIVATE DUTY NURSING		
14 CLINIC		
15 HEALTH PROM ACTIVITIES		
16 DAY CARE PROGRAM		
17 HOME DEL MEALS PROGRAM		
18 HOMEMAKER SERVICE		
19 ALL OTHER		
19.50 TELEMEDICINE		
20 TOTAL (SUM OF 1-19) (2)	469,915	2,074,179
21 UNIT COST MULTIPLIER	0.292916	

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

Health Financial Systems MCRIF32
 ALLOCATION OF GENERAL SERVICE
 COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

FOR JASPER COUNTY HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/26/2011
I	15-1324	I	FROM 1/ 1/2010	I	WORKSHEET	H-5
I	HHA NO:	I	TO 12/31/2010	I	PART II	
I	15-7149	I		I		

HHA 1

MEDICAL RECO	SOCIAL SERVI
RDS & LIBRAR	CE
(TIME	(TIME
SPENT) SPENT
17	18

HHA COST CENTER

- 1 ADMIN & GENERAL
- 2 SKILLED NURSING CARE
- 3 PHYSICAL THERAPY
- 4 OCCUPATIONAL THERAPY
- 5 SPEECH PATHOLOGY
- 6 MEDICAL SOCIAL SERVICES
- 7 HOME HEALTH AIDE
- 8 SUPPLIES
- 9 DRUGS
- 9.20 COST ADMINISTERING DRUGS
- 10 DME
- 11 HOME DIALYSIS AIDE SVCS
- 12 RESPIRATORY THERAPY
- 13 PRIVATE DUTY NURSING
- 14 CLINIC
- 15 HEALTH PROM ACTIVITIES
- 16 DAY CARE PROGRAM
- 17 HOME DEL MEALS PROGRAM
- 18 HOMEMAKER SERVICE
- 19 ALL OTHER
- 19.50 TELEMEDICINE
- 20 TOTAL (SUM OF 1-19)
- 21 COST TO BE ALLOCATED
- 22 UNIT COST MULTIPLIER

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS PART A
1 SKILLED NURSING	2	1,467,708	2	1,467,708	5,639	260.28	2,216
2 PHYSICAL THERAPY	3		266,113	266,113	2,988	89.06	1,498
3 OCCUPATIONAL THERAPY	4		154,010	154,010	1,043	147.66	651
4 SPEECH PATHOLOGY	5		27,959	27,959	171	163.50	96
5 MEDICAL SOCIAL SERVICES	6	12,346		12,346	33	374.12	19
6 HOME HEALTH AIDE SERVICE	7	594,125		594,125	7,615	78.02	786
7 TOTAL		2,074,179	448,082	2,522,261	17,489		5,266

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST	
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	SUBJECT TO DEDUCT & COINSUR		
1 SKILLED NURSING	7	8	9	10	11	12
2 PHYSICAL THERAPY	1,469	764	576,780	382,351	959,131	
3 OCCUPATIONAL THERAPY	274	34	133,412	68,042	201,454	
4 SPEECH PATHOLOGY	3	3	96,127	40,459	136,586	
5 MEDICAL SOCIAL SERVICES	1,202	3,746	15,696	5,559	21,255	
6 HOME HEALTH AIDE SERVICES			7,108	1,122	8,230	
7 TOTAL			61,324	93,780	155,104	
			890,447	591,313	1,481,760	

LIMITATION COST COMPUTATION	1	2	3	4	PROGRAM COST LIMITS	PROGRAM VISITS PART A
8 SKILLED NURSING						6
9 PHYSICAL THERAPY						
10 OCCUPATIONAL THERAPY						
11 SPEECH PATHOLOGY						
12 MEDICAL SOCIAL SERVICES						
13 HOME HEALTH AIDE SERVICE						
14 TOTAL						

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST	
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	SUBJECT TO DEDUCT & COINSUR		
8 SKILLED NURSING	7	8	9	10	11	12
9 PHYSICAL THERAPY						
10 OCCUPATIONAL THERAPY						
11 SPEECH PATHOLOGY						
12 MEDICAL SOCIAL SERVICES						
13 HOME HEALTH AIDE SERVICE						
14 TOTAL						

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:

COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS 3	TOTAL CHARGES 4	RATIO 5	PROGRAM COVERED CHARGES PART A 6
15 COST OF MEDICAL SUPPLIES	8.00		6,071	6,071	19,212	.316000	8,127
16 COST OF DRUGS	9.00						
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES		COST OF SERVICES	
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	NOT SUBJECT TO DEDUCT & COINSUR 9	SUBJECT TO DEDUCT & COINSUR 10
15 COST OF MEDICAL SUPPLIES	11,085		2,568	3,503
16 COST OF DRUGS				
16.20 COST OF DRUGS				

PER BENEFICIARY COST LIMITATION:	MSA NUMBER 1	AMOUNT 2
162 PROGRAM UNDUP CENSUS FROM WRKST S-4		
17 PER BENE COST LIMITATION (FRM FI)		
18 PER BENE COST LIMITATION (LN 17*18)		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO 1	TOTAL HHA CHARGES 2	HHA SHARED ANCILLARY COSTS 3	TRANSFER TO PART I AS INDICATED 4
1 PHYSICAL THERAPY	50	.712484	373,500	266,113	COL 2, LN 2
1.01 KV HEALTH & DEMOTTE PT	50.01	.814390			
2 OCCUPATIONAL THERAPY	51	1.181285	130,375	154,010	COL 2, LN 3
2.01 KV HEALTH & DEMOTTE OT	51.01	1.347088			
3 SPEECH PATHOLOGY	52	1.211154	23,085	27,959	COL 2, LN 4
3.01 KV HEALTH & DEMOTTE ST	52.01	1.481789			
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.295674	19,212	5,680	COL 2, LN 15
4.30 IMPL. DEV. CHARGED TO PATIENT	55.30	.393559	994	391	
5 DRUGS CHARGED TO PATIENTS	56	.385109			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5 1	COST PER VISIT 2	PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE		PROGRAM COSTS		PROG VISITS ON OR AFTER 1/1/1999 5
			PRIOR 1/1/1998 2.01	1/1/1998 TO 12/31/1998 3	PRIOR 1/1/1998 3.01	1/1/1998 TO 12/31/1998 4	
1 PHYSICAL THERAPY		89.06					
2 OCCUPATIONAL THERAPY		147.66					
3 SPEECH PATHOLOGY		163.50					
4 TOTAL (SUM OF LINES 1-3)							

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET H-7
 I HHA NO: I TO 12/31/2010 I PARTS I & II
 I 15-7149 I I

TITLE XVIII HHA 1

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	PART A	PART B NOT SUBJECT TO DED & COINS	PART B SUBJECT TO DED & COINS
	1	2	3
1 REASONABLE COST OF SERVICES			
2 TOTAL CHARGES			
CUSTOMARY CHARGES			
3 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
4 AMOUNT 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(B)			
5 RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)			
6 TOTAL CUSTOMARY CHARGES			
7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST			
8 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
9 PRIMARY PAYOR AMOUNTS			

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	PART A SERVICES	PART B SERVICES
	1	2
10 TOTAL REASONABLE COST		
10.01 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	787,147	451,848
10.02 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	8,209	2,362
10.03 TOTAL PPS REIMBURSEMENT-LUPA EPISODES	9,500	7,690
10.04 TOTAL PPS REIMBURSEMENT-PEP EPISODES	5,006	890
10.05 TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.06 TOTAL PPS REIMBURSEMENT-SCIC EPISODES		
10.07 TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	1,774	1,855
10.08 TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES		
10.09 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES		
10.11 TOTAL OTHER PAYMENTS		
10.12 DME PAYMENTS		
10.13 OXYGEN PAYMENTS		
10.14 PROSTHETIC AND ORTHOTIC PAYMENTS		
11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)		
12 SUBTOTAL	811,636	464,645
13 EXCESS REASONABLE COST		
14 SUBTOTAL	811,636	464,645
15 COINSURANCE BILLED TO PROGRAM PATIENTS		
16 NET COST	811,636	464,645
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	811,636	464,645
19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
21 OTHER ADJUSTMENTS (SPECIFY)		994
22 SUBTOTAL	811,636	465,639
23 SEQUESTRATION ADJUSTMENT		
24 SUBTOTAL	811,636	465,639
25 INTERIM PAYMENTS	811,636	465,639
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE PROVIDER/PROGRAM		
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2		

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET H-8
 I HHA NO: I TO 12/31/2010 I
 I 15-7149 I I

TITLE XVIII HHA 1

DESCRIPTION	P A R T A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		811,636		465,639
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 PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
ADJUSTMENTS TO PROGRAM .99				
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		811,636		465,639
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				
TENTATIVE TO PROGRAM .99				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY		811,636		465,639

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

RECLASSIFICATION AND ADJUSTMENT
OF TRIAL BALANCE EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K
I HOSPICE NO: I TO 12/31/2010 I
I 15-1519 I I

HOSPICE 1

	SALARIES (FROM K-1) 1	EMPLOYEE BENEFITS (FROM K-2) 2	TRANSPORTATION (SEE INST.) 3	CONTRACTED SERVICES (FROM K-3) 4
GENERAL SERVICE COST CENTERS				
1 CAPITAL RELATED COSTS-BLDG AND FIXT.				
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.				
3 PLANT OPERATION AND MAINTENANCE				
4 TRANSPORTATION - STAFF				
5 VOLUNTEER SERVICE COORDINATION				
6 ADMINISTRATIVE AND GENERAL	17,185			
INPATIENT CARE SERVICE				
7 INPATIENT - GENERAL CARE				
8 INPATIENT - RESPITE CARE				
VISITING SERVICES				
9 PHYSICIAN SERVICES				
10 NURSING CARE	33,921			
10.20 NURSING CARE-CONTINUOUS HOME CARE				
11 PHYSICAL THERAPY				
12 OCCUPATIONAL THERAPY				
13 SPEECH/LANGUAGE PATHOLOGY				
14 MEDICAL SOCIAL SERVICES	19,449			
15 SPIRITUAL COUNSELING				
16 DIETARY COUNSELING				
17 COUNSELING - OTHER				
18 HOME HEALTH AIDE AND HOMEMAKER	4,775			
18.20 HH AIDE & HOMEMAKER-CONT. HOME CARE				
OTHER HOSPICE SERVICE COSTS				
19 OTHER				
20 DRUGS BIOLOGICAL AND INFUSION THERAPY				
20.30 ANALGESICS				
20.31 SEDATIVES / HYPNOTICS				
20.32 OTHER - SPECIFY				
21 DURABLE MEDICAL EQUIPMENT/OXYGEN				
22 PATIENT TRANSPORTATION				
23 IMAGING SERVICES				
24 LABS AND DIAGNOSTICS				
25 MEDICAL SUPPLIES				
26 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
27 RADIATION THERAPY				
28 CHEMOTHERAPY				
29 OTHER				
30 BEREAVEMENT PROGRAM COSTS				
31 VOLUNTEER PROGRAM COSTS				
32 FUNDRAISING				
33 OTHER PROGRAM COSTS				
34 TOTAL (SUM OF LINES 1 THRU 33)	75,330			

RECLASSIFICATION AND ADJUSTMENT
OF TRIAL BALANCE EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K
I HOSPICE NO: I TO 12/31/2010 I
I 15-1519 I I

HOSPICE 1

	OTHER 5	TOTAL (COLS. 1-5) 6	RECLASSIFICATIONS 7	SUBTOTAL (COL. 6 + COL. 7) 8
GENERAL SERVICE COST CENTERS				
1 CAPITAL RELATED COSTS-BLDG AND FIXT.				
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.				
3 PLANT OPERATION AND MAINTENANCE				
4 TRANSPORTATION - STAFF				
5 VOLUNTEER SERVICE COORDINATION				
6 ADMINISTRATIVE AND GENERAL	189,345	206,530	167,789	374,319
INPATIENT CARE SERVICE				
7 INPATIENT - GENERAL CARE				
8 INPATIENT - RESPITE CARE				
VISITING SERVICES				
9 PHYSICIAN SERVICES				
10 NURSING CARE		33,921		33,921
10.20 NURSING CARE-CONTINUOUS HOME CARE				
11 PHYSICAL THERAPY				
12 OCCUPATIONAL THERAPY				
13 SPEECH/LANGUAGE PATHOLOGY				
14 MEDICAL SOCIAL SERVICES		19,449		19,449
15 SPIRITUAL COUNSELING				
16 DIETARY COUNSELING				
17 COUNSELING - OTHER				
18 HOME HEALTH AIDE AND HOMEMAKER		4,775		4,775
18.20 HH AIDE & HOMEMAKER-CONT. HOME CARE				
OTHER HOSPICE SERVICE COSTS				
19 OTHER				
20 DRUGS BIOLOGICAL AND INFUSION THERAPY				
20.30 ANALGESICS				
20.31 SEDATIVES / HYPNOTICS				
20.32 OTHER - SPECIFY				
21 DURABLE MEDICAL EQUIPMENT/OXYGEN				
22 PATIENT TRANSPORTATION				
23 IMAGING SERVICES				
24 LABS AND DIAGNOSTICS				
25 MEDICAL SUPPLIES				
26 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
27 RADIATION THERAPY				
28 CHEMOTHERAPY				
29 OTHER				
30 BEREAVEMENT PROGRAM COSTS				
31 VOLUNTEER PROGRAM COSTS				
32 FUNDRAISING				
33 OTHER PROGRAM COSTS				
34 TOTAL (SUM OF LINES 1 THRU 33)	189,345	264,675	167,789	432,464

RECLASSIFICATION AND ADJUSTMENT
OF TRIAL BALANCE EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K
I HOSPICE NO: I TO 12/31/2010 I
I 15-1519 I I

HOSPICE 1

	ADJUSTMENTS	TOTAL (COL. 8 + COL. 9)
	9	10
GENERAL SERVICE COST CENTERS		
1 CAPITAL RELATED COSTS-BLDG AND FIXT.		
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.		
3 PLANT OPERATION AND MAINTENANCE		
4 TRANSPORTATION - STAFF		
5 VOLUNTEER SERVICE COORDINATION		
6 ADMINISTRATIVE AND GENERAL		374,319
INPATIENT CARE SERVICE		
7 INPATIENT - GENERAL CARE		
8 INPATIENT - RESPITE CARE		
VISITING SERVICES		
9 PHYSICIAN SERVICES		
10 NURSING CARE		33,921
10.20 NURSING CARE-CONTINUOUS HOME CARE		
11 PHYSICAL THERAPY		
12 OCCUPATIONAL THERAPY		
13 SPEECH/LANGUAGE PATHOLOGY		
14 MEDICAL SOCIAL SERVICES		19,449
15 SPIRITUAL COUNSELING		
16 DIETARY COUNSELING		
17 COUNSELING - OTHER		
18 HOME HEALTH AIDE AND HOMEMAKER		4,775
18.20 HH AIDE & HOMEMAKER-CONT. HOME CARE		
OTHER HOSPICE SERVICE COSTS		
19 OTHER		
20 DRUGS BIOLOGICAL AND INFUSION THERAPY		
20.30 ANALGESICS		
20.31 SEDATIVES / HYPNOTICS		
20.32 OTHER - SPECIFY		
21 DURABLE MEDICAL EQUIPMENT/OXYGEN		
22 PATIENT TRANSPORTATION		
23 IMAGING SERVICES		
24 LABS AND DIAGNOSTICS		
25 MEDICAL SUPPLIES		
26 OUTPATIENT SERVICES (INCL. E/R DEPT.)		
27 RADIATION THERAPY		
28 CHEMOTHERAPY		
29 OTHER		
30 BEREAVEMENT PROGRAM COSTS		
31 VOLUNTEER PROGRAM COSTS		
32 FUNDRAISING		
33 OTHER PROGRAM COSTS		
34 TOTAL (SUM OF LINES 1 THRU 33)		432,464

COMPENSATION ANALYSIS
SALARIES AND WAGES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-1
 I HOSPICE NO: I TO 12/31/2010 I
 I 15-1519 I I

HOSPICE 1

	ADMINISTRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPERVISORS 4
GENERAL SERVICE COST CENTERS				
1 CAPITAL RELATED COSTS-BLDG AND FIXT.				
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.				
3 PLANT OPERATION AND MAINTENANCE				
4 TRANSPORTATION - STAFF				
5 VOLUNTEER SERVICE COORDINATION				
6 ADMINISTRATIVE AND GENERAL	17,185			
INPATIENT CARE SERVICE				
7 INPATIENT - GENERAL CARE				
8 INPATIENT - RESPITE CARE				
VISITING SERVICES				
9 PHYSICIAN SERVICES				
10 NURSING CARE	33,921			
10.20 NURSING CARE-CONTINUOUS HOME CARE				
11 PHYSICAL THERAPY				
12 OCCUPATIONAL THERAPY				
13 SPEECH/LANGUAGE PATHOLOGY				
14 MEDICAL SOCIAL SERVICES			19,449	
15 SPIRITUAL COUNSELING				
16 DIETARY COUNSELING				
17 COUNSELING - OTHER				
18 HOME HEALTH AIDE AND HOMEMAKER				
18.20 HH AIDE & HOMEMAKER-CONT. HOME CARE				
OTHER HOSPICE SERVICE COSTS				
19 OTHER				
20 DRUGS BIOLOGICAL AND INFUSION THERAPY				
20.30 ANALGESICS				
20.31 SEDATIVES / HYPNOTICS				
20.32 OTHER - SPECIFY				
21 DURABLE MEDICAL EQUIPMENT/OXYGEN				
22 PATIENT TRANSPORTATION				
23 IMAGING SERVICES				
24 LABS AND DIAGNOSTICS				
25 MEDICAL SUPPLIES				
26 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
27 RADIATION THERAPY				
28 CHEMOTHERAPY				
29 OTHER				
30 BEREAVEMENT PROGRAM COSTS				
31 VOLUNTEER PROGRAM COSTS				
32 FUNDRAISING				
33 OTHER PROGRAM COSTS				
34 TOTAL (SUM OF LINES 1 THRU 33)	51,106		19,449	

COMPENSATION ANALYSIS
SALARIES AND WAGES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-1
I HOSPICE NO: I TO 12/31/2010 I
I 15-1519 I I

HOSPICE 1

	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8
1 GENERAL SERVICE COST CENTERS				
2 CAPITAL RELATED COSTS-BLDG AND FIXT.				
3 CAPITAL RELATED COSTS-MOVABLE EQUIP.				
4 PLANT OPERATION AND MAINTENANCE				
5 TRANSPORTATION - STAFF				
6 VOLUNTEER SERVICE COORDINATION				
7 ADMINISTRATIVE AND GENERAL				
8 INPATIENT CARE SERVICE				
9 INPATIENT - GENERAL CARE				
10 INPATIENT - RESPITE CARE				
11 VISITING SERVICES				
12 PHYSICIAN SERVICES				
13 NURSING CARE				
14 NURSING CARE-CONTINUOUS HOME CARE				
15 PHYSICAL THERAPY				
16 OCCUPATIONAL THERAPY				
17 SPEECH/LANGUAGE PATHOLOGY				
18 MEDICAL SOCIAL SERVICES				
19 SPIRITUAL COUNSELING				
20 DIETARY COUNSELING				
21 COUNSELING - OTHER				
22 HOME HEALTH AIDE AND HOMEMAKER			4,775	
23 HH AIDE & HOMEMAKER-CONT. HOME CARE				
24 OTHER HOSPICE SERVICE COSTS				
25 OTHER				
26 DRUGS BIOLOGICAL AND INFUSION THERAPY				
27 ANALGESICS				
28 SEDATIVES / HYPNOTICS				
29 OTHER - SPECIFY				
30 DURABLE MEDICAL EQUIPMENT/OXYGEN				
31 PATIENT TRANSPORTATION				
32 IMAGING SERVICES				
33 LABS AND DIAGNOSTICS				
34 MEDICAL SUPPLIES				
35 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
36 RADIATION THERAPY				
37 CHEMOTHERAPY				
38 OTHER				
39 BEREAVEMENT PROGRAM COSTS				
40 VOLUNTEER PROGRAM COSTS				
41 FUNDRAISING				
42 OTHER PROGRAM COSTS				
43 TOTAL (SUM OF LINES 1 THRU 33)			4,775	

COMPENSATION ANALYSIS
SALARIES AND WAGES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-1
I HOSPICE NO: I TO 12/31/2010 I
I 15-1519 I I

HOSPICE 1

TOTAL (1)
9

GENERAL SERVICE COST CENTERS		
1	CAPITAL RELATED COSTS-BLDG AND FIXT.	
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.	
3	PLANT OPERATION AND MAINTENANCE	
4	TRANSPORTATION - STAFF	
5	VOLUNTEER SERVICE COORDINATION	
6	ADMINISTRATIVE AND GENERAL	17,185
	INPATIENT CARE SERVICE	
7	INPATIENT - GENERAL CARE	
8	INPATIENT - RESPITE CARE	
	VISITING SERVICES	
9	PHYSICIAN SERVICES	
10	NURSING CARE	33,921
10.20	NURSING CARE-CONTINUOUS HOME CARE	
11	PHYSICAL THERAPY	
12	OCCUPATIONAL THERAPY	
13	SPEECH/LANGUAGE PATHOLOGY	
14	MEDICAL SOCIAL SERVICES	19,449
15	SPIRITUAL COUNSELING	
16	DIETARY COUNSELING	
17	COUNSELING - OTHER	
18	HOME HEALTH AIDE AND HOMEMAKER	4,775
18.20	HH AIDE & HOMEMAKER-CONT. HOME CARE	
	OTHER HOSPICE SERVICE COSTS	
19	OTHER	
20	DRUGS BIOLOGICAL AND INFUSION THERAPY	
20.30	ANALGESICS	
20.31	SEDATIVES / HYPNOTICS	
20.32	OTHER - SPECIFY	
21	DURABLE MEDICAL EQUIPMENT/OXYGEN	
22	PATIENT TRANSPORTATION	
23	IMAGING SERVICES	
24	LABS AND DIAGNOSTICS	
25	MEDICAL SUPPLIES	
26	OUTPATIENT SERVICES (INCL. E/R DEPT.)	
27	RADIATION THERAPY	
28	CHEMOTHERAPY	
29	OTHER	
30	BEREAVEMENT PROGRAM COSTS	
31	VOLUNTEER PROGRAM COSTS	
32	FUNDRAISING	
33	OTHER PROGRAM COSTS	
34	TOTAL (SUM OF LINES 1 THRU 33)	75,330

(1) TRANSFER THE AMOUNT IN COLUMN 9 TO WKST K, COLUMN 1

COST ALLOCATION -
HOSPICE GENERAL SERVICE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-4
I HOSPICE NO: I TO 12/31/2010 I PART I
I 15-1519 I I

HOSPICE 1

	NET EXPENSES FOR COST ALLOC. (FROM K, COL. 10)	CAP. REL. COST BUILDINGS & FIXTURES	CAP. REL. COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.
	0	1	2	3
GENERAL SERVICE COST CENTERS				
1 CAPITAL RELATED COSTS-BLDG AND FIXT.				
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.				
3 PLANT OPERATION AND MAINTENANCE				
4 TRANSPORTATION - STAFF				
5 VOLUNTEER SERVICE COORDINATION				
6 ADMINISTRATIVE AND GENERAL	374,319			
INPATIENT CARE SERVICE				
7 INPATIENT - GENERAL CARE				
8 INPATIENT - RESPITE CARE				
VISITING SERVICES				
9 PHYSICIAN SERVICES				
10 NURSING CARE	33,921			
10.20 NURSING CARE-CONTINUOUS HOME CARE				
11 PHYSICAL THERAPY				
12 OCCUPATIONAL THERAPY				
13 SPEECH/LANGUAGE PATHOLOGY				
14 MEDICAL SOCIAL SERVICES	19,449			
15 SPIRITUAL COUNSELING				
16 DIETARY COUNSELING				
17 COUNSELING - OTHER				
18 HOME HEALTH AIDE AND HOMEMAKER	4,775			
18.20 HH AIDE & HOMEMAKER-CONT. HOME CARE				
OTHER HOSPICE SERVICE COSTS				
19 OTHER				
20 DRUGS BIOLOGICAL AND INFUSION THERAPY				
20.30 ANALGESICS				
20.31 SEDATIVES / HYPNOTICS				
20.32 OTHER - SPECIFY				
21 DURABLE MEDICAL EQUIPMENT/OXYGEN				
22 PATIENT TRANSPORTATION				
23 IMAGING SERVICES				
24 LABS AND DIAGNOSTICS				
25 MEDICAL SUPPLIES				
26 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
27 RADIATION THERAPY				
28 CHEMOTHERAPY				
29 OTHER				
30 BEREAVEMENT PROGRAM COSTS				
31 VOLUNTEER PROGRAM COSTS				
32 FUNDRAISING				
33 OTHER PROGRAM COSTS				
34 TOTAL (SUM OF LINES 1 THRU 33)	432,464			

COST ALLOCATION -
HOSPICE GENERAL SERVICE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-4
 I HOSPICE NO: I TO 12/31/2010 I PART I
 I 15-1519 I I

HOSPICE 1

	TRANSPORTATION	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (COL. 0-5)	ADMINISTRATIVE & GENERAL
	4	5	5A	6
1 GENERAL SERVICE COST CENTERS				
2 CAPITAL RELATED COSTS-BLDG AND FIXT.				
3 CAPITAL RELATED COSTS-MOVABLE EQUIP.				
4 PLANT OPERATION AND MAINTENANCE				
5 TRANSPORTATION - STAFF				
6 VOLUNTEER SERVICE COORDINATION				
7 ADMINISTRATIVE AND GENERAL			374,319	374,319
8 INPATIENT CARE SERVICE				
9 INPATIENT - GENERAL CARE				
10 INPATIENT - RESPITE CARE				
11 VISITING SERVICES				
12 PHYSICIAN SERVICES				
13 NURSING CARE			33,921	218,373
14 NURSING CARE-CONTINUOUS HOME CARE				
15 PHYSICAL THERAPY				
16 OCCUPATIONAL THERAPY				
17 SPEECH/LANGUAGE PATHOLOGY				
18 MEDICAL SOCIAL SERVICES			19,449	125,206
19 SPIRITUAL COUNSELING				
20 DIETARY COUNSELING				
21 COUNSELING - OTHER				
22 HOME HEALTH AIDE AND HOMEMAKER			4,775	30,740
23 HH AIDE & HOMEMAKER-CONT. HOME CARE				
24 OTHER HOSPICE SERVICE COSTS				
25 OTHER				
26 DRUGS BIOLOGICAL AND INFUSION THERAPY				
27 ANALGESICS				
28 SEDATIVES / HYPNOTICS				
29 OTHER - SPECIFY				
30 DURABLE MEDICAL EQUIPMENT/OXYGEN				
31 PATIENT TRANSPORTATION				
32 IMAGING SERVICES				
33 LABS AND DIAGNOSTICS				
34 MEDICAL SUPPLIES				
35 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
36 RADIATION THERAPY				
37 CHEMOTHERAPY				
38 OTHER				
39 BEREAVEMENT PROGRAM COSTS				
40 VOLUNTEER PROGRAM COSTS				
41 FUNDRAISING				
42 OTHER PROGRAM COSTS				
43 TOTAL (SUM OF LINES 1 THRU 33)			58,145	374,319

COST ALLOCATION -
HOSPICE GENERAL SERVICE COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/26/2011
I	15-1324	I	FROM 1/ 1/2010	I	WORKSHEET	K-4
I	HOSPICE NO:	I	TO 12/31/2010	I	PART I	
I	15-1519	I		I		

HOSPICE 1

TOTAL
(COL. 5A
+ COL. 6)

7

1	GENERAL SERVICE COST CENTERS	
1	CAPITAL RELATED COSTS-BLDG AND FIXT.	
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.	
3	PLANT OPERATION AND MAINTENANCE	
4	TRANSPORTATION - STAFF	
5	VOLUNTEER SERVICE COORDINATION	
6	ADMINISTRATIVE AND GENERAL	
	INPATIENT CARE SERVICE	
7	INPATIENT - GENERAL CARE	
8	INPATIENT - RESPITE CARE	
	VISITING SERVICES	
9	PHYSICIAN SERVICES	
10	NURSING CARE	252,294
10.20	NURSING CARE-CONTINUOUS HOME CARE	
11	PHYSICAL THERAPY	
12	OCCUPATIONAL THERAPY	
13	SPEECH/LANGUAGE PATHOLOGY	
14	MEDICAL SOCIAL SERVICES	144,655
15	SPIRITUAL COUNSELING	
16	DIETARY COUNSELING	
17	COUNSELING - OTHER	
18	HOME HEALTH AIDE AND HOMEMAKER	35,515
18.20	HH AIDE & HOMEMAKER-CONT. HOME CARE	
	OTHER HOSPICE SERVICE COSTS	
19	OTHER	
20	DRUGS BIOLOGICAL AND INFUSION THERAPY	
20.30	ANALGESICS	
20.31	SEDATIVES / HYPNOTICS	
20.32	OTHER - SPECIFY	
21	DURABLE MEDICAL EQUIPMENT/OXYGEN	
22	PATIENT TRANSPORTATION	
23	IMAGING SERVICES	
24	LABS AND DIAGNOSTICS	
25	MEDICAL SUPPLIES	
26	OUTPATIENT SERVICES (INCL. E/R DEPT.)	
27	RADIATION THERAPY	
28	CHEMOTHERAPY	
29	OTHER	
30	BEREAVEMENT PROGRAM COSTS	
31	VOLUNTEER PROGRAM COSTS	
32	FUNDRAISING	
33	OTHER PROGRAM COSTS	
34	TOTAL (SUM OF LINES 1 THRU 33)	432,464

COST ALLOCATION -
HOSPICE STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-4
 I HOSPICE NO: I TO 12/31/2010 I PART II
 I 15-1519 I I

HOSPICE 1

	CAP. REL. COST BUILDINGS & FIXTURES (SQUARE FEET) 1	CAP. REL. COST MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATION & MAINT. (SQUARE FEET) 3	TRANSPORTATION (MILEAGE) 4
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
10.20				
11				
12				
13				
14				
15				
16				
17				
18				
18.20				
19				
20				
20.30				
20.31				
20.32				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
	.000000	.000000	.000000	.000000

COST ALLOCATION -
HOSPICE STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-4
 I HOSPICE NO: I TO 12/31/2010 I PART II
 I 15-1519 I I

HOSPICE 1

	VOLUNTEER SERVICES COORDINATOR (HOURS) 5	RECONCILIATION 6A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 6
1 GENERAL SERVICE COST CENTERS			
2 CAPITAL RELATED COSTS-BLDG AND FIXT.			
3 CAPITAL RELATED COSTS-MOVABLE EQUIP.			
4 PLANT OPERATION AND MAINTENANCE			
5 TRANSPORTATION - STAFF			
6 VOLUNTEER SERVICE COORDINATION			
7 ADMINISTRATIVE AND GENERAL		-374,319	58,145
8 INPATIENT CARE SERVICE			
9 INPATIENT - GENERAL CARE			
10 INPATIENT - RESPITE CARE			
11 VISITING SERVICES			
12 PHYSICIAN SERVICES			
13 NURSING CARE			33,921
14.20 NURSING CARE-CONTINUOUS HOME CARE			
15 PHYSICAL THERAPY			
16 OCCUPATIONAL THERAPY			
17 SPEECH/LANGUAGE PATHOLOGY			
18 MEDICAL SOCIAL SERVICES			19,449
19 SPIRITUAL COUNSELING			
20 DIETARY COUNSELING			
21 COUNSELING - OTHER			
22 HOME HEALTH AIDE AND HOMEMAKER			4,775
23.20 HH AIDE & HOMEMAKER-CONT. HOME CARE			
24 OTHER HOSPICE SERVICE COSTS			
25 OTHER			
26 DRUGS BIOLOGICAL AND INFUSION THERAPY			
27.30 ANALGESICS			
28.31 SEDATIVES / HYPNOTICS			
29.32 OTHER - SPECIFY			
30 DURABLE MEDICAL EQUIPMENT/OXYGEN			
31 PATIENT TRANSPORTATION			
32 IMAGING SERVICES			
33 LABS AND DIAGNOSTICS			
34 MEDICAL SUPPLIES			
35 OUTPATIENT SERVICES (INCL. E/R DEPT.)			
36 RADIATION THERAPY			
37 CHEMOTHERAPY			
38 OTHER			
39			
40			
41			
42 FUNDRAISING			
43 OTHER PROGRAM COSTS			
44 COST TO BE ALLOCATED (PER WKST K-4, PART I)			374,319
45 UNIT COST MULTIPLIER	.000000		6.437682

ALLOCATION OF GENERAL SERVICES COSTS TO HOSPICE COST CENTERS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-5
 I HOSPICE NO: I TO 12/31/2010 I PART I
 I 15-1519 I I I

HOSPICE 1

HOSPICE COST CENTER	FROM K-4, PART I, COLUMN 7, LINE	HOSPICE TRIAL BALANCE (1)	NEW CAP REL COSTS-BLDG & FIXT	EMPLOYEE BENEFITS	SUBTOTAL
		0	3	5	5A
1.00 ADMINISTRATIVE AND GENERAL	6		1,251	19,618	20,869
2.00 INPATIENT - GENERAL CARE	7				
3.00 INPATIENT - RESPITE CARE	8				
4.00 PHYSICIAN SERVICES	9				
5.00 NURSING CARE	10	252,294			252,294
5.20 NURSING CARE-CONTINUOUS HOME CARE	10.20				
6.00 PHYSICAL THERAPY	11				
7.00 OCCUPATIONAL THERAPY	12				
8.00 SPEECH/LANGUAGE PATHOLOGY	13				
9.00 MEDICAL SOCIAL SERVICES	14	144,655			144,655
10.00 SPIRITUAL COUNSELING	15				
11.00 DIETARY COUNSELING	16				
12.00 COUNSELING - OTHER	17				
13.00 HOME HEALTH AIDE AND HOMEMAKER	18	35,515			35,515
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE	18.20				
14.00	19				
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY	20				
15.30 ANALGESICS	20.30				
15.31 SEDATIVES / HYPNOTICS	20.31				
15.32 OTHER	20.32				
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	21				
17.00 PATIENT TRANSPORTATION	22				
18.00 IMAGING SERVICES	23				
19.00 LABS AND DIAGNOSTICS	24				
20.00 MEDICAL SUPPLIES	25				
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)	26				
22.00 RADIATION THERAPY	27				
23.00 CHEMOTHERAPY	28				
24.00	29				
25.00 BEREAVEMENT PROGRAM COSTS	30				
26.00 VOLUNTEER PROGRAM COSTS	31				
27.00 FUNDRAISING	32				
28.00 OTHER PROGRAM COSTS	33				
29.00 TOTAL (SUM OF LINE 1 THRU 28) (2)		432,464	1,251	19,618	453,333
30.00 UNIT COST MULTIPLIER					

ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING

HOSPICE COST CENTER	6	8	9	10
1.00 ADMINISTRATIVE AND GENERAL	3,771	2,790		
2.00 INPATIENT - GENERAL CARE				
3.00 INPATIENT - RESPITE CARE				
4.00 PHYSICIAN SERVICES				
5.00 NURSING CARE	45,583			
5.20 NURSING CARE-CONTINUOUS HOME CARE				
6.00 PHYSICAL THERAPY				
7.00 OCCUPATIONAL THERAPY				
8.00 SPEECH/LANGUAGE PATHOLOGY				
9.00 MEDICAL SOCIAL SERVICES	26,136			
10.00 SPIRITUAL COUNSELING				
11.00 DIETARY COUNSELING				
12.00 COUNSELING - OTHER				
13.00 HOME HEALTH AIDE AND HOMEMAKER	6,417			
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE				
14.00				
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY				
15.30 ANALGESICS				
15.31 SEDATIVES / HYPNOTICS				
15.32 OTHER				
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				
17.00 PATIENT TRANSPORTATION				
18.00 IMAGING SERVICES				
19.00 LABS AND DIAGNOSTICS				
20.00 MEDICAL SUPPLIES				
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
22.00 RADIATION THERAPY				
23.00 CHEMOTHERAPY				
24.00				
25.00 BEREAVEMENT PROGRAM COSTS				
26.00 VOLUNTEER PROGRAM COSTS				
27.00 FUNDRAISING				
28.00 OTHER PROGRAM COSTS				
29.00 TOTAL (SUM OF LINE 1 THRU 28) (2)	81,907	2,790		
30.00 UNIT COST MULTIPLIER				

ALLOCATION OF GENERAL SERVICES COSTS TO HOSPICE
COST CENTERS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-5
 I HOSPICE NO: I TO 12/31/2010 I PART I
 I 15-1519 I I I

HOSPICE 1

	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY
HOSPICE COST CENTER	11	12	14	15
1.00 ADMINISTRATIVE AND GENERAL				
2.00 INPATIENT - GENERAL CARE				
3.00 INPATIENT - RESPITE CARE				
4.00 PHYSICIAN SERVICES				
5.00 NURSING CARE				
5.20 NURSING CARE-CONTINUOUS HOME CARE				
6.00 PHYSICAL THERAPY				
7.00 OCCUPATIONAL THERAPY				
8.00 SPEECH/LANGUAGE PATHOLOGY				
9.00 MEDICAL SOCIAL SERVICES				
10.00 SPIRITUAL COUNSELING				
11.00 DIETARY COUNSELING				
12.00 COUNSELING - OTHER				
13.00 HOME HEALTH AIDE AND HOMEMAKER				
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE				
14.00				
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY				
15.30 ANALGESICS				
15.31 SEDATIVES / HYPNOTICS				
15.32 OTHER				
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				
17.00 PATIENT TRANSPORTATION				
18.00 IMAGING SERVICES				
19.00 LABS AND DIAGNOSTICS				
20.00 MEDICAL SUPPLIES				
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
22.00 RADIATION THERAPY				
23.00 CHEMOTHERAPY				
24.00				
25.00 BEREAVEMENT PROGRAM COSTS				
26.00 VOLUNTEER PROGRAM COSTS				
27.00 FUNDRAISING				
28.00 OTHER PROGRAM COSTS				
29.00 TOTAL (SUM OF LINE 1 THRU 28) (2)				
30.00 UNIT COST MULTIPLIER				

	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL
HOSPICE COST CENTER	16	17	18	25
1.00 ADMINISTRATIVE AND GENERAL				27,430
2.00 INPATIENT - GENERAL CARE				
3.00 INPATIENT - RESPITE CARE				
4.00 PHYSICIAN SERVICES				
5.00 NURSING CARE				297,877
5.20 NURSING CARE-CONTINUOUS HOME CARE				
6.00 PHYSICAL THERAPY				
7.00 OCCUPATIONAL THERAPY				
8.00 SPEECH/LANGUAGE PATHOLOGY				
9.00 MEDICAL SOCIAL SERVICES				170,791
10.00 SPIRITUAL COUNSELING				
11.00 DIETARY COUNSELING				
12.00 COUNSELING - OTHER				
13.00 HOME HEALTH AIDE AND HOMEMAKER				41,932
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE				
14.00				
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY				
15.30 ANALGESICS				
15.31 SEDATIVES / HYPNOTICS				
15.32 OTHER				
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				
17.00 PATIENT TRANSPORTATION				
18.00 IMAGING SERVICES				
19.00 LABS AND DIAGNOSTICS				
20.00 MEDICAL SUPPLIES				
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
22.00 RADIATION THERAPY				
23.00 CHEMOTHERAPY				
24.00				
25.00 BEREAVEMENT PROGRAM COSTS				
26.00 VOLUNTEER PROGRAM COSTS				
27.00 FUNDRAISING				
28.00 OTHER PROGRAM COSTS				
29.00 TOTAL (SUM OF LINE 1 THRU 28) (2)				538,030
30.00 UNIT COST MULTIPLIER				

ALLOCATION OF GENERAL SERVICES COSTS TO HOSPICE
COST CENTERS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-5
I HOSPICE NO: I TO 12/31/2010 I PART I
I 15-1519 I I

HOSPICE 1

HOSPICE COST CENTER	INTRN & RSDNT COST & POST STEPDWN AD	SUBTOTAL	ALLOCATED HOSPICE A & G	TOTAL HOSPICE COSTS
	26	27	28	29
1.00 ADMINISTRATIVE AND GENERAL		27,430		
2.00 INPATIENT - GENERAL CARE				
3.00 INPATIENT - RESPITE CARE				
4.00 PHYSICIAN SERVICES				
5.00 NURSING CARE		297,877	16,002	313,879
5.20 NURSING CARE-CONTINUOUS HOME CARE				
6.00 PHYSICAL THERAPY				
7.00 OCCUPATIONAL THERAPY				
8.00 SPEECH/LANGUAGE PATHOLOGY				
9.00 MEDICAL SOCIAL SERVICES		170,791	9,175	179,966
10.00 SPIRITUAL COUNSELING				
11.00 DIETARY COUNSELING				
12.00 COUNSELING - OTHER				
13.00 HOME HEALTH AIDE AND HOMEMAKER		41,932	2,253	44,185
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE				
14.00				
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY				
15.30 ANALGESICS				
15.31 SEDATIVES / HYPNOTICS				
15.32 OTHER				
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				
17.00 PATIENT TRANSPORTATION				
18.00 IMAGING SERVICES				
19.00 LABS AND DIAGNOSTICS				
20.00 MEDICAL SUPPLIES				
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
22.00 RADIATION THERAPY				
23.00 CHEMOTHERAPY				
24.00				
25.00 BEREAVEMENT PROGRAM COSTS				
26.00 VOLUNTEER PROGRAM COSTS				
27.00 FUNDRAISING				
28.00 OTHER PROGRAM COSTS				
29.00 TOTAL (SUM OF LINE 1 THRU 28) (2)		538,030		538,030
30.00 UNIT COST MULTIPLIER			.053721	

(1) COLUMN 0, LINE 29 MUST AGREE WITH WKST. A, COLUMN 7, LINE 93.

(2) COLUMNS 0 THROUGH 27, LINE 29 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, LINE 93.

ALLOCATION OF GENERAL SERVICES COSTS TO HOSPICE
COST CENTERS - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-5
I HOSPICE NO: I TO 12/31/2010 I PART II
I 15-1519 I I

HOSPICE 1

HOSPICE COST CENTER	NEW CAP REL COSTS-BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION 6A	ADMINISTRATIVE & GENERAL (ACCUMULATED COST)
	3	5		6
1.00 ADMINISTRATIVE AND GENERAL	249	75,330		20,869
2.00 INPATIENT - GENERAL CARE				
3.00 INPATIENT - RESPITE CARE				
4.00 PHYSICIAN SERVICES				
5.00 NURSING CARE				252,294
5.20 NURSING CARE-CONTINUOUS HOME CARE				
6.00 PHYSICAL THERAPY				
7.00 OCCUPATIONAL THERAPY				
8.00 SPEECH/LANGUAGE PATHOLOGY				
9.00 MEDICAL SOCIAL SERVICES				144,655
10.00 SPIRITUAL COUNSELING				
11.00 DIETARY COUNSELING				
12.00 COUNSELING - OTHER				
13.00 HOME HEALTH AIDE AND HOMEMAKER				35,515
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE				
14.00				
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY				
15.30 ANALGESICS				
15.31 SEDATIVES / HYPNOTICS				
15.32 OTHER				
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				
17.00 PATIENT TRANSPORTATION				
18.00 IMAGING SERVICES				
19.00 LABS AND DIAGNOSTICS				
20.00 MEDICAL SUPPLIES				
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
22.00 RADIATION THERAPY				
23.00 CHEMOTHERAPY				
24.00				
25.00 BEREAVEMENT PROGRAM COSTS				
26.00 VOLUNTEER PROGRAM COSTS				
27.00 FUNDRAISING				
28.00 OTHER PROGRAM COSTS				
29.00 TOTAL (SUM OF LINE 1 THRU 28)	249	75,330		453,333
30.00 TOTAL COST TO BE ALLOCATED	1,251	19,618		81,907
31.00 UNIT COST MULTIPLIER	5.024096	.260427		.180677

HOSPICE COST CENTER	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)
	8	9	10	11
1.00 ADMINISTRATIVE AND GENERAL	249			
2.00 INPATIENT - GENERAL CARE				
3.00 INPATIENT - RESPITE CARE				
4.00 PHYSICIAN SERVICES				
5.00 NURSING CARE				
5.20 NURSING CARE-CONTINUOUS HOME CARE				
6.00 PHYSICAL THERAPY				
7.00 OCCUPATIONAL THERAPY				
8.00 SPEECH/LANGUAGE PATHOLOGY				
9.00 MEDICAL SOCIAL SERVICES				
10.00 SPIRITUAL COUNSELING				
11.00 DIETARY COUNSELING				
12.00 COUNSELING - OTHER				
13.00 HOME HEALTH AIDE AND HOMEMAKER				
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE				
14.00				
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY				
15.30 ANALGESICS				
15.31 SEDATIVES / HYPNOTICS				
15.32 OTHER				
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				
17.00 PATIENT TRANSPORTATION				
18.00 IMAGING SERVICES				
19.00 LABS AND DIAGNOSTICS				
20.00 MEDICAL SUPPLIES				
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
22.00 RADIATION THERAPY				
23.00 CHEMOTHERAPY				
24.00				
25.00 BEREAVEMENT PROGRAM COSTS				
26.00 VOLUNTEER PROGRAM COSTS				
27.00 FUNDRAISING				
28.00 OTHER PROGRAM COSTS				

ALLOCATION OF GENERAL SERVICES COSTS TO HOSPICE
 COST CENTERS - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-5
 I HOSPICE NO: I TO 12/31/2010 I PART II
 I 15-1519 I I

HOSPICE 1

HOSPICE COST CENTER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
	8	9	10	11
29.00 TOTAL (SUM OF LINE 1 THRU 28)	249			
30.00 TOTAL COST TO BE ALLOCATED	2,790			
31.00 UNIT COST MULTIPLIER	11.204819	.000000	.000000	.000000

HOSPICE COST CENTER	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
	(MAN HOURS)	(MAN HOURS)	(100% ALLOCATION)	(100% ALLOCATION)
	12	14	15	16

1.00 ADMINISTRATIVE AND GENERAL				
2.00 INPATIENT - GENERAL CARE				
3.00 INPATIENT - RESPITE CARE				
4.00 PHYSICIAN SERVICES				
5.00 NURSING CARE				
5.20 NURSING CARE-CONTINUOUS HOME CARE				
6.00 PHYSICAL THERAPY				
7.00 OCCUPATIONAL THERAPY				
8.00 SPEECH/LANGUAGE PATHOLOGY				
9.00 MEDICAL SOCIAL SERVICES				
10.00 SPIRITUAL COUNSELING				
11.00 DIETARY COUNSELING				
12.00 COUNSELING - OTHER				
13.00 HOME HEALTH AIDE AND HOMEMAKER				
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE				
14.00				
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY				
15.30 ANALGESICS				
15.31 SEDATIVES / HYPNOTICS				
15.32 OTHER				
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN				
17.00 PATIENT TRANSPORTATION				
18.00 IMAGING SERVICES				
19.00 LABS AND DIAGNOSTICS				
20.00 MEDICAL SUPPLIES				
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)				
22.00 RADIATION THERAPY				
23.00 CHEMOTHERAPY				
24.00				
25.00 BEREAVEMENT PROGRAM COSTS				
26.00 VOLUNTEER PROGRAM COSTS				
27.00 FUNDRAISING				
28.00 OTHER PROGRAM COSTS				
29.00 TOTAL (SUM OF LINE 1 THRU 28)				
30.00 TOTAL COST TO BE ALLOCATED				
31.00 UNIT COST MULTIPLIER	.000000	.000000	.000000	.000000

ALLOCATION OF GENERAL SERVICES COSTS TO HOSPICE
 COST CENTERS - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-5
 I HOSPICE NO: I TO 12/31/2010 I PART II
 I 15-1519 I I

HOSPICE 1

MEDICAL RECORDS & LIBRARY SOCIAL SERVICE

HOSPICE COST CENTER	(TIME SPENT)	(TIME SPENT)
	17	18
1.00 ADMINISTRATIVE AND GENERAL		
2.00 INPATIENT - GENERAL CARE		
3.00 INPATIENT - RESPITE CARE		
4.00 PHYSICIAN SERVICES		
5.00 NURSING CARE		
5.20 NURSING CARE-CONTINUOUS HOME CARE		
6.00 PHYSICAL THERAPY		
7.00 OCCUPATIONAL THERAPY		
8.00 SPEECH/LANGUAGE PATHOLOGY		
9.00 MEDICAL SOCIAL SERVICES		
10.00 SPIRITUAL COUNSELING		
11.00 DIETARY COUNSELING		
12.00 COUNSELING - OTHER		
13.00 HOME HEALTH AIDE AND HOMEMAKER		
13.20 HH AIDE&HOMEMAKER- CONT. HOME CARE		
14.00		
15.00 DRUGS BIOLOGICAL AND INFUSION THERAPY		
15.30 ANALGESICS		
15.31 SEDATIVES / HYPNOTICS		
15.32 OTHER		
16.00 DURABLE MEDICAL EQUIPMENT/OXYGEN		
17.00 PATIENT TRANSPORTATION		
18.00 IMAGING SERVICES		
19.00 LABS AND DIAGNOSTICS		
20.00 MEDICAL SUPPLIES		
21.00 OUTPATIENT SERVICES (INCL. E/R DEPT.)		
22.00 RADIATION THERAPY		
23.00 CHEMOTHERAPY		
24.00		
25.00 BEREAVEMENT PROGRAM COSTS		
26.00 VOLUNTEER PROGRAM COSTS		
27.00 FUNDRAISING		
28.00 OTHER PROGRAM COSTS		
29.00 TOTAL (SUM OF LINE 1 THRU 28)		
30.00 TOTAL COST TO BE ALLOCATED		
31.00 UNIT COST MULTIPLIER	.000000	.000000

ALLOCATION OF GENERAL SERVICES COSTS TO HOSPICE
 COST CENTERS - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-5
 I HOSPICE NO: I TO 12/31/2010 I PART III
 I 15-1519 I I

HOSPICE 1

	WKSHT C, PART I COLUMN 9 LINE:	COST TO CHARGE RATIO 1	TOTAL HOSPICE CHARGES 2	HOSPICE SHARED ANCILLARY COSTS 3
1	PHYSICAL THERAPY	50	.712484	
1.01	KV HEALTH & DEMOTTE PT	50.01	.814390	
2	OCCUPATIONAL THERAPY	51	1.181285	
2.01	KV HEALTH & DEMOTTE OT	51.01	1.347088	
3	SPEECH PATHOLOGY	52	1.211154	
3.01	KV HEALTH & DEMOTTE ST	52.01	1.481789	
4	DRUGS CHARGED TO PATIENTS	56	.385109	
5	DURABLE MEDICAL EQUIP-SOLD	67		
6	LABORATORY	44	.340013	
7	MEDICAL SUPPLIES CHARGED TO PATIENTS	55	.295674	
7.30	IMPL. DEV. CHARGED TO PATIENT	55.30	.393559	
8	EMERGENCY	61	1.254957	
9	RADIOLOGY-DIAGNOSTIC	41	.495606	
10	OTHER ANCILLARY	59		
11	TOTAL (SUM OF LINES 1-10)			

CALCULATION OF PER DIEM COST

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET K-6
 I HOSPICE NO: I TO 12/31/2010 I
 I 15-1519 I I

HOSPICE 1

COMPUTATION OF PER DIEM COST

	TITLE XVIII	TITLE XIX	OTHER	TOTAL(1)
	1	2	3	4
1 TOTAL COST (WORKSHEET K-5, PART I, COL. 29, LINE 2 9 LESS COL. 29, LINE 28 PLUS WORKSHEET K-5, PART III, COL. 4, LINE 11) (SEE INSTRUCTIONS)				538,030
2 TOTAL UNDUPLICATED DAYS (S-9, LINE 9, COL. 4)				2,436
3 AVERAGE COST PER DIEM (LINE 1 DIVIDED BY LINE 2)				220.87
4 UNDUPLICATED MEDICARE DAYS (S-9, LINE 9, COL. 1)	2,132			
5 AGGREGATE MEDICARE COST (LINE 3 TIMES LINE 4)	470,895			
6 UNDUPLICATED MEDICAID DAYS			37	
7 AGGREGATE MEDICAID COST			8,172	
8 UNDUPLICATED SNF DAYS (S-9, LINE 9, COL. 2)	1,150			
9 AGGREGATE SNF COST (LINE 3 TIMES LINE 8)	254,001			
10 UNDUPLICATED NF DAYS			888	
11 AGGREGATE NF COST		196,133		
12 OTHER UNDUPLICATED DAYS (S-9, LINE 9, COL. 3)			267	
13 AGGREGATE COST FOR OTHER DAYS (LN 3 TIMES LN 12)			58,972	

NOTE: THE DATA FOR THE SNF AND NF LINES 8 THROUGH 11 ARE INCLUDED IN THE MEDICARE AND MEDICAID LINES 4 THROUGH 7.

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 15-3990 I I

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN				
3 PHYSICIAN ASSISTANT				
4 NURSE PRACTITIONER	104,210		104,210	
5 VISITING NURSE				
6 OTHER NURSE	51,808		51,808	
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN				
10 OTHER FACILITY HEALTH CARE STAFF COSTS				
10 SUBTOTAL (SUM OF LINES 1-9)	156,018		156,018	
11 COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT		27,113	27,113	
13 PHYSICIAN SUPERVISION UNDER AGREEMENT				
14 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)		27,113	27,113	
15 OTHER HEALTH CARE COSTS				
16 MEDICAL SUPPLIES		13,200	13,200	
17 TRANSPORTATION (HEALTH CARE STAFF)				
18 DEPRECIATION-MEDICAL EQUIPMENT				
19 PROFESSIONAL LIABILITY INSURANCE				
20 OTHER HEALTH CARE COSTS				
21 ALLOWABLE GME COSTS				
21 SUBTOTAL (SUM OF LINES 15-20)		13,200	13,200	
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	156,018	40,313	196,331	
23 COSTS OTHER THAN RHC/FQHC SERVICES				
24 PHARMACY				
25 DENTAL				
26 OPTOMETRY				
27 ALL OTHER NONREIMBURSABLE COSTS				
28 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
29 FACILITY OVERHEAD				
30 FACILITY COSTS				
30 ADMINISTRATIVE COSTS	88,647	36,454	125,101	
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	88,647	36,454	125,101	
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	244,665	76,767	321,432	

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 15-3990 I I

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN			
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	104,210		104,210
5 VISITING NURSE			
6 OTHER NURSE	51,808		51,808
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN			
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	156,018		156,018
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT	27,113		27,113
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)	27,113		27,113
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	13,200		13,200
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE			
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	13,200		13,200
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	196,331		196,331
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY			
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS			
27 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	125,101	-11,829	113,272
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	125,101	-11,829	113,272
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	321,432	-11,829	309,603

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 15-8502 I I

RHC 4

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2				
3				
4				
5				
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9				
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22				
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30				
31				
32				

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 15-8502 I I

RHC 4

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN			
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	141,543		141,543
5 VISITING NURSE			
6 OTHER NURSE	39,197		39,197
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN			
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	180,740		180,740
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT	50,921		50,921
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)	50,921		50,921
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	15,293		15,293
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE			
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	15,293		15,293
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	246,954		246,954
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY			
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS			
28 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	102,695		102,695
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	102,695		102,695
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	349,649		349,649

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-2
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-8502 I I

RHC 4

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS		4,200	
2	PHYSICIAN ASSISTANTS		2,100	
3	NURSE PRACTITIONERS	1.50	5,509	3,150
4	SUBTOTAL (SUM OF LINES 1-3)	1.50	5,509	3,150
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	1.50	5,509	
9	PHYSICIAN SERVICES UNDER AGREEMENTS		9	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	246,954		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	246,954		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	102,695		
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	186,435		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	289,130		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	289,130		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	289,130		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	536,084		
		GREATER OF COL. 2 OR COL. 4 5		
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	5,509		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	5,509		
9	PHYSICIAN SERVICES UNDER AGREEMENTS		9	

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

I PROVIDER NO:	I PERIOD:	I PREPARED
I 15-1324	I FROM 1/ 1/2010	I 5/26/2011
I COMPONENT NO:	I TO 12/31/2010	I WORKSHEET M-3
I 15-3990	I	I

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	440,772
	(FROM WORKSHEET M-2, LINE 20)	
2	COST OF VACCINES AND THEIR ADMINISTRATION	4,934
	(FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	435,838
	(LINE 1 MINUS LINE 2)	
4	TOTAL VISITS	5,181
	(FROM WORKSHEET M-2, COLUMN 5, LINE 8)	
5	PHYSICIANS VISITS UNDER AGREEMENT	96
	(FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,277
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	82.59

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	77.76
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	82.59
10	CALCULATION OF SETTLEMENT	
	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	203
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	16,766
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)	
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)	
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)	
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*	16,766
16.01	PRIMARY PAYER AMOUNT	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	3,729
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	13,037
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	10,430
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	1,476
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	11,906
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	11,906
25	INTERIM PAYMENTS	11,436
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	470
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2	

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-3
I COMPONENT NO: I TO 12/31/2010 I
I 15-8502 I I

TITLE XVIII RHC 4

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES	UCATION PASS THROUGH COST.
1 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	536,084
2 COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	8,982
3 TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	527,102
4 TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	5,509
5 PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	9
6 TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,518
7 ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	95.52

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8 PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)		77.76
9 RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	95.52	95.52
10 CALCULATION OF SETTLEMENT		
PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		648
11 PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		61,897
12 PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13 PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14 LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15 GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16 TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		61,897
16.01 PRIMARY PAYER AMOUNT		
17 LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		8,825
18 NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		53,072
19 REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		42,458
20 PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		5,476
21 TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		47,934
22 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23 OTHER ADJUSTMENTS (SPECIFY)		
24 NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		47,934
25 INTERIM PAYMENTS		50,280
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		-2,346
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-3990 I I

TITLE XVIII

RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	156,018	156,018	156,018	156,018
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000200	.004447		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	31	694		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	252	1,221		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	283	1,915		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	196,331	196,331	196,331	196,331
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	244,441	244,441	244,441	244,441
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.001441	.009754		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	352	2,384		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	635	4,299		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	5	111		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	127.00	38.73		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	4	25		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	508	968		
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		4,934		
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		1,476		

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-8502 I I

TITLE XVIII

RHC 4

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	180,740	180,740	180,740	180,740
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.001587	.005337		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	287	965		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	1,665	1,221		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,952	2,186		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	246,954	246,954	246,954	246,954
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	289,130	289,130	289,130	289,130
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.007904	.008852		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	2,285	2,559		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	4,237	4,745		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	33	111		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	128.39	42.75		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	22	62		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	2,825	2,651		
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		8,982		
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		5,476		

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES
 [X] RHC [] FQHC

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-5
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-3990 I I

RHC 1

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1		12,382
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
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 PROVIDER			.49
ADJUSTMENTS TO PROGRAM	8/ 5/2010		.50
ADJUSTMENTS TO PROGRAM			.51
ADJUSTMENTS TO PROGRAM			.52
ADJUSTMENTS TO PROGRAM			.53
ADJUSTMENTS TO PROGRAM			.54
SUBTOTAL			-946
4 TOTAL INTERIM PAYMENTS			11,436
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
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			NONE
SETTLEMENT TO PROVIDER			.01
SETTLEMENT TO PROGRAM			.02
7 TOTAL MEDICARE PROGRAM LIABILITY			11,906

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES
 [X] RHC [] FQHC

I PROVIDER NO: I PERIOD: I PREPARED 5/26/2011
 I 15-1324 I FROM 1/ 1/2010 I WORKSHEET M-5
 I COMPONENT NO: I TO 12/31/2010 I
 I 15-8502 I I

RHC 4

DESCRIPTION	P A R T		B
	MM/DD/YYYY	AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	2	52,251
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
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 PROVIDER .49			
ADJUSTMENTS TO PROGRAM .50	8/ 5/2010		1,971
ADJUSTMENTS TO PROGRAM .51			
ADJUSTMENTS TO PROGRAM .52			
ADJUSTMENTS TO PROGRAM .53			
ADJUSTMENTS TO PROGRAM .54			
SUBTOTAL .99			-1,971
4 TOTAL INTERIM PAYMENTS			50,280
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
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			
SETTLEMENT TO PROVIDER .01			
SETTLEMENT TO PROGRAM .02			2,346
7 TOTAL MEDICARE PROGRAM LIABILITY			47,934

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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