

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT  
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
 PARTS I & II

INTERMEDIARY [ ] AUDITED DATE RECEIVED \_\_\_\_\_ [ ] INITIAL [ ] RE-OPENING  
 USE ONLY: [ ] DESK REVIEWED INTERMEDIARY NO. \_\_\_\_\_ [ ] FINAL [ ] MCR CODE

PART I - CERTIFICATION

CHECK \_\_\_\_\_ ELECTRONICALLY FILED COST REPORT DATE: \_\_\_\_\_  
 APPLICABLE BOX \_\_\_\_\_ MANUALLY SUBMITTED COST REPORT TIME: \_\_\_\_\_

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 IN 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 HOOPESTON COMMUNITY MEMORIAL HOSPITAL (14-1316) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2008 AND ENDING 09/30/2009, 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.

(SIGNED) \_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	2	3	4	1
2	SUBPROVIDER I	80425	252912	39318	2
3	SWING BED - SNF	70117			3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY	7057			5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	RURAL HEALTH CLINIC I		-34356		9
9.01	RURAL HEALTH CLINIC II		7382		9.01
9.02	RURAL HEALTH CLINIC III		21930		9.02
100	TOTAL	157599	247868	39318	100

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 657 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: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.



HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO							25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO							25.01
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.	NO							25.02
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.	NO							25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO							25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO					NO		25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO					NO		25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.								26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:								26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.								26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:								26.04
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.	YES					11/01/2001		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.	NO							28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st	100					0.8320 0.8320		28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.	2						14	28.02
<p>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 INSTRUCTIONS)</p>									
28.03	STAFFING	0.00					N		28.03
28.04	RECRUITMENT	0.00					N		28.04
28.05	RETENTION OF EMPLOYEES	0.00					N		28.05
28.06	TRAINING	0.00					N		28.06
28.07	OTHER (SPECIFY)								28.07
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?	NO							29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES							30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO							30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO							30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE 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)	NO							30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE 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.	NO							30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO							31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO				32
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.	NO				33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO				34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO				35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES				38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO				38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO				38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO				38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO				38.04

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	NO				40
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40.01	NAME:	FI/CONTRACTOR'S NUMBER:				40.01
40.02	STREET:	P.O.BOX:				40.02
40.03	CITY:	STATE:	ZIP CODE:			40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES				41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES				42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES				42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES				42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO				43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO				44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO				45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?					45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?					45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?					45.03
46	IF YOU ARE PARTICIPATING IN THE NCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.					46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A '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	HOSPITAL	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N	N	N	49
50	HOME HEALTH AGENCY	N	N	N	N	50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO				52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.	NO				52.01
53	IF THIS IS 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.					53
53.01	MDH PERIOD:	BEGINNING:	ENDING:			53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:					54
	PREMIUMS:	PAID LOSSES:	AND/OR SELF INSURANCE:			
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.	NO				54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO				55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

		DATE	Y/N	LIMIT	Y/N	FEE\$	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
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% 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.		NO				58
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 IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? 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 INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59
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)		NO				60
60.01	IF LINE 60 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.)						60.01
MULTICAMPUS							
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? 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.		NO				61
	COUNTY:	STATE:	ZIP CODE	CBSA	FTE/ CAMPUS		
	1	2	3	4	5		
SETTLEMENT DATA							
63	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 COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		NO				63





HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS
	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TITLE XX 15	
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		268	26	453	1
2 HMO XIX					2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4 HOSPITAL ADULTS & PEDS - SWING BED NF					4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6 INTENSIVE CARE UNIT					6
7 CORONARY CARE UNIT					7
8 BURN INTENSIVE CARE UNIT					8
9 SURGICAL INTENSIVE CARE UNIT					9
10 OTHER SPECIAL CARE (SPECIFY)					10
11 NURSERY					11
12 TOTAL HOSPITAL		268	26	453	12
13 RPCH VISITS					13
14 SUBPROVIDER I					14
15 SKILLED NURSING FACILITY					15
16 NURSING FACILITY					16
17 OTHER LONG TERM CARE					17
18 HOME HEALTH AGENCY					18
20 ASC (DISTINCT PART)					20
21 HOSPICE (DISTINCT PART)					21
23 O/P REHAB PROVIDER					23
24 RHC I					24
24.01 RHC II					24.01
24.02 RHC III					24.02
25 TOTAL					25
26 OBSERVATION BED DAYS					26
27 AMBULANCE TRIPS					27
28 EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA		AMOUNT	RECLASS. OF SALARIES FROM WKST.	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	WORKSHEET S-3 PART II
		1	A-6 2	3	4	5	6	
1	SALARIES							
1	TOTAL SALARIES	7114823	-82744		433611.00			1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF	1217920	-3024		89329.00			8
8.01	EXCLUDED AREA SALARIES	436883			43829.00			8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	1059367					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	328489					CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)						CMS 339	19.01
20	INTERNS & RESIDENTS (IN APPR PGM)							20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	91568			3688.00			21
22	ADMINISTRATIVE & GENERAL	709426	106310		39298.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	184680			15827.00			24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING	246401			26846.00			26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	327541			33057.00			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	100478	-97715		2104.00			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	214419	62539		14123.00			33
34	SOCIAL SERVICE	49443			2082.00			34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT	RECLASS. OF SALARIES FROM WKST.	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)		WORKSHEET S-3 PART III
		1	A-6 2	3	4	5		
1	NET SALARIES	7114823	-82744	7032079	433611.00	16.22		1
2	EXCLUDED AREA SALARIES	1654803	-3024	1651779	133158.00	12.40		2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5460020	-79720	5380300	300453.00	17.91		3
4	SUBTOTAL OTHER WAGES & REL COSTS							4
5	SUBTOTAL WAGE-RELATED COSTS	1059367		1059367		19.69%		5
6	TOTAL (SUM OF LINES 3 THRU 5)	6519387	-79720	6439667	300453.00	21.43		6
7	NET SALARIES							7
8	EXCLUDED AREA SALARIES							8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)							9
10	SUBTOTAL OTHER WAGES & REL COSTS							10
11	SUBTOTAL WAGE-RELATED COSTS							11
12	TOTAL (SUM OF LINES 9 THRU 11)							12
13	TOTAL OVERHEAD COSTS	1923956	71134	1995090	137025.00	14.56		13

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

GROUP (1)	M3PI REVENUE CODE	SERVICES PRIOR TO OCTOBER 1st		SERVICES ON OR AFTER OCTOBER 1st		SERVICES THROUGH 4/1/2001 - 9/30/2001		SWING BED SNF DAYS	TOTAL
		RATE	DAYS	RATE	DAYS	RATE	DAYS		
1	2	3	3.01	4	4.01	4.02	4.03	4.06	5
1	RUC								1
2	RUB								2
3	RUA								3
3.01	RUX								3.01
3.02	RUL								3.02
4	RVC		14						4
5	RVB		49						5
6	RVA		27						6
6.01	RVX		16						6.01
6.02	RVL								6.02
7	RHC		30						7
8	RHB		28						8
9	RHA		11						9
9.01	RHX								9.01
9.02	RHL								9.02
10	RMC		46						10
11	RMB		49						11
12	RMA		16						12
12.01	RMX		90						12.01
12.02	RML		49						12.02
13	RLB								13
14	RLA								14
14.01	RLX								14.01
15	SE3		43						15
16	SE2		75						16
17	SE1								17
18	SSC								18
19	SSB								19
20	SSA		21						20
21	CC2								21
22	CC1		3						22
23	CB2								23
24	CB1		24						24
25	CA2								25
26	CA1		23						26
27	IB2								27
28	IB1								28
29	IA2								29
30	IA1								30
31	BB2								31
32	BB1								32
33	BA2								33
34	BA1								34
35	PE2								35
36	PE1								36
37	PD2								37
38	PD1								38
39	PC2								39
40	PC1								40
41	PB2								41
42	PB1								42
43	PA2								43
44	PA1								44
45	DEFAULT RATE								45
46	TOTAL		614						46

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
02/11/2010 11:52

RHC I  
COMPONENT NO: 14-3448

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 801 EAST ORANGE STREET 1  
1.01 CITY: HOOPESTON STATE: IL ZIP CODE: 60452 COUNTY: VERMILLION 1.01  
2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

3 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 1 / / 3  
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) / / 4  
5 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) / / 5  
6 APPALACHIAN REGIONAL COMMISSION / / 6  
7 LOOK-ALIKES / / 7  
8 OTHER / / 8

PHYSICIAN INFORMATION:

PHYSICIAN NAME

BILLING NO.

9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT 9

PHYSICIAN NAME

HOURS

10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD 10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11  
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 CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14
			830	1830	830	1830	830	1700	830	1700	830	1700		

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS 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? NO 13

14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? NO 14  
IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.

15 LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW. PROVIDER NUMBER: - 15  
V XVIII XIX

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. NO 17  
IF YES, SEE INSTRUCTIONS.

PROVIDER NO. 14-1316 HOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
02/11/2010 11:52

RHC II  
COMPONENT NO: 14-3485

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 141 W GARFIELD AVE. 1  
1.01 CITY: CISSNA PARK STATE: IL ZIP CODE: 60924 COUNTY: IRIQUOIS 1.01  
2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

3 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 1 / / 3  
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) / / 4  
5 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) / / 5  
6 APPALACHIAN REGIONAL COMMISSION / / 6  
7 LOOK-ALIKES / / 7  
8 OTHER / / 8

PHYSICIAN INFORMATION:

PHYSICIAN NAME

BILLING NO.

9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT 9

PHYSICIAN NAME

HOURS

10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD 10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11  
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 CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14
			830	1300	830	1300	830	1300	830	1300	830	1300		

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS 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.

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IF YES, SEE INSTRUCTIONS.

PROVIDER NO. 14-1316 HOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
02/11/2010 11:52

RHC III  
COMPONENT NO: 14-3496

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: ROSSVILLE CLINIC 1  
1.01 CITY: STATE: ZIP CODE: COUNTY: 1.01  
2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

3 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 1 / / 3  
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) / / 4  
5 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) / / 5  
6 APPALACHIAN REGIONAL COMMISSION / / 6  
7 LOOK-ALIKES / / 7  
8 OTHER / / 8

PHYSICIAN INFORMATION:

PHYSICIAN NAME

BILLING NO.

9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT 9

PHYSICIAN NAME

HOURS

10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD 10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11  
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															12

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)  
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IF YES, SEE INSTRUCTIONS.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
	GENERAL SERVICE COST CENTERS								
1	0100 OLD CAP REL COSTS-BLDG & FIXT								1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT		363750	363750	279441	643191	-2722	640469	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		345990	345990	184401	530391		530391	4
5	0500 EMPLOYEE BENEFITS	91568	32484	124052	627961	752013	-3434	748579	5
6	0600 ADMINISTRATIVE & GENERAL	709426	3625348	4334774	-963867	3370907	-116273	3254634	6
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT	184680	435639	620319	24556	644875		644875	8
9	0900 LAUNDRY & LINEN SERVICE		97903	97903		97903		97903	9
10	1000 HOUSEKEEPING	246401	66178	312579		312579		312579	10
11	1100 DIETARY	327541	336599	664140		664140	-60674	603466	11
12	1200 CAFETERIA								12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION	100478	9835	110313	-97715	12598		12598	14
15	1500 CENTRAL SERVICES & SUPPLY								15
16	1600 PHARMACY								16
17	1700 MEDICAL RECORDS & LIBRARY	214419	48289	262708	62539	325247	-2941	322306	17
18	1800 SOCIAL SERVICE	49443	4566	54009		54009		54009	18
20	2000 NONPHYSICIAN ANESTHETISTS								20
21	2100 NURSING SCHOOL								21
22	2200 I&R SERVICES-SALARY & FRINGES A								22
23	2300 I&R SERVICES-OTHER PRGM COSTS A								23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	2500 ADULTS & PEDIATRICS	715832	139476	855308	-68092	787216		787216	25
34	3400 SKILLED NURSING FACILITY	1217920	248748	1466668	37243	1503911		1503911	34
	ANCILLARY SERVICE COST CENTERS								
37	3700 OPERATING ROOM	147941	631035	778976	-526719	252257		252257	37
40	4000 ANESTHESIOLOGY	110628	12841	123469		123469	-88872	34597	40
41	4100 RADIOLOGY-DIAGNOSTIC	343910	462710	806620	-24666	781954		781954	41
44	4400 LABORATORY	294812	376232	671044	-7280	663764	-8000	655764	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900 RESPIRATORY THERAPY	21711	46511	68222		68222	-13323	54899	49
50	5000 PHYSICAL THERAPY	35346	423030	458376		458376		458376	50
51	5100 OCCUPATIONAL THERAPY								51
52	5200 SPEECH PATHOLOGY								52
55	5500 MEDICAL SUPPLIES CHARGED TO PAT		256582	256582	489344	745926		745926	55
56	5600 DRUGS CHARGED TO PATIENTS	57631	566530	624161		624161		624161	56
	OUTPATIENT SERVICE COST CENTERS								
60	6000 CLINIC	20816	55991	76807		76807		76807	60
61	6100 EMERGENCY	655591	1072294	1727885	-4523	1723362	-547546	1175816	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RHC	855491	142321	997812	-55623	942189		942189	63.50
63.51	6311 RHC II	33542	34095	67637		67637		67637	63.51
63.52	6312 RHC III	242813	59517	302330		302330		302330	63.52
63.60	6320 FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	6500 AMBULANCE SERVICES	305976	103019	408995	-6645	402350		402350	65
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTESTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	6983916	9997513	16981429	-49645	16931784	-843785	16087999	95
	NONREIMBURSABLE COST CENTERS								
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN								96
99.01	9901 ASSISTED LIVING	130907	33148	164055	49645	213700		213700	99.01
100	7950 FOUNDATION								100
101	TOTAL	7114823	10030661	17145484		17145484	-843785	16301699	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
1		2	3		4	5
1 INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3			377433
2						2
3						3
4 RENT EXPENSE	B	NEW CAP REL COSTS-MVBLE EQUIP	4			184401
5	B					5
6	B					6
7	B					7
8	B					8
9	B					9
10	B					10
11						11
12 CAPITAL INSURANCE	C	NEW CAP REL COSTS-BLDG & FIXT	3			28562
13						13
14						14
15 EMPLOYEE BENEFITS	D	EMPLOYEE BENEFITS	5			627961
16						16
17 UTILITY EXPENSE	E	OPERATION OF PLANT	8			24806
18	E					18
19	E					19
20						20
21 ACTIVITIES THERAPY	F	ADULTS & PEDIATRICS	25		3024	550
22						22
23 INSURANCE EXPENSE	G	ADMINISTRATIVE & GENERAL	6			82834
24	G					24
25						25
26 CRNA SALARIES	H	ANESTHESIOLOGY	40			82744
27						27
28 HOSPITALIST	I	EMERGENCY	61			71666
29						29
30 DEPRECIATION EXPENSE	J	SKILLED NURSING FACILITY	34			47312
31	J	RHC	63.50			29597
32	J	ASSISTED LIVING	99.01			49645
33						33
34 MEDICAL SUPPLIES	K	MEDICAL SUPPLIES CHARGED TO P	55			512276
35						35
36 SUBTOTAL					3024	2119787

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE	SALARY	OTHER	WKST A-7
			LINE #			REF.
	1	6	7	8	9	10
1 INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	6		377433	11 1
2						2
3						3
4 RENT EXPENSE	B	ADMINISTRATIVE & GENERAL	6		111986	11 4
5	B	OPERATION OF PLANT	8		250	5
6	B	OPERATING ROOM	37		14443	6
7	B	RADIOLOGY-DIAGNOSTIC	41		24666	7
8	B	LABORATORY	44		7280	8
9	B	MEDICAL SUPPLIES CHARGED TO P	55		22932	9
10	B	SKILLED NURSING FACILITY	34		2844	10
11						11
12 CAPITAL INSURANCE	C	ADMINISTRATIVE & GENERAL	6		28562	11 12
13						13
14						14
15 EMPLOYEE BENEFITS	D	ADMINISTRATIVE & GENERAL	6		627961	15
16						16
17 UTILITY EXPENSE	E	ADMINISTRATIVE & GENERAL	6		7069	17
18	E	SKILLED NURSING FACILITY	34		3651	18
19	E	RHC	63.50		14086	19
20						20
21 ACTIVITIES THERAPY	F	SKILLED NURSING FACILITY	34	3024	550	21
22						22
23 INSURANCE EXPENSE	G	EMERGENCY	61		76189	23
24	G	AMBULANCE SERVICES	65		6645	24
25						25
26 CRNA SALARIES	H	ANESTHESIOLOGY	40	82744		26
27						27
28 HOSPITALIST	I	ADULTS & PEDIATRICS	25		71666	28
29						29
30 DEPRECIATION EXPENSE	J	NEW CAP REL COSTS-BLDG & FIXT	3		126554	9 30
31	J					31
32	J					32
33						33
34 MEDICAL SUPPLIES	K	OPERATING ROOM	37		512276	34
35						35
36 SUBTOTAL				85768	2037043	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
1		2	3		4	5
1 ADMINISTRATIVE SALARIES	L	ADMINISTRATIVE & GENERAL	6		106310	1
2	L	MEDICAL RECORDS & LIBRARY	17		62539	2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS					171873	2119787

RECLASSIFICATIONS

1	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
				LINE #	SALARY	OTHER	
1		1	6	7	8	9	10
2	ADMINISTRATIVE SALARIES	L	NURSING ADMINISTRATION	14	97715		1
3		L	RHC	63.50	71134		2
4							3
5							4
6							5
7							6
8							7
9							8
10							9
11							10
12							11
13							12
14							13
15							14
16							15
17							16
18							17
19							18
20							19
21							20
22							21
23							22
24							23
25							24
26							25
27							26
28							27
29							28
30							29
31							30
32							31
33							32
34							33
35							34
36	TOTAL RECLASSIFICATIONS				254617	2037043	35

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

WORKSHEET A-7  
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	164876					164876		1
2 LAND IMPROVEMENTS	208101					208101		2
3 BUILDINGS AND FIXTURES	9175082	672948		672948		9848030		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	274015					274015		5
6 MOVABLE EQUIPMENT	3229831	895166		895166		4124997		6
7 SUBTOTAL	13051905	1568114		1568114		14620019		7
8 RECONCILING ITEMS								8
9 TOTAL	13051905	1568114		1568114		14620019		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF		OTHER CAPITAL	TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	RELATED COSTS	
	1	2	3	4	5	6	7	
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT				.000000				3
4 NEW CAP REL COSTS-MVBLE EQUIP				.000000				4
5 TOTAL				.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	234474		405995				640469 3
4 NEW CAP REL COSTS-MVBLE EQUIP	345990		184401				530391 4
5 TOTAL	580464		590396				1170860 5

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	363750						363750 3
4 NEW CAP REL COSTS-MVBLE EQUIP	345990						345990 4
5 TOTAL	709740						709740 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO.	WKST A-7 REF
			COST CENTER			
	1	2	3		4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT		1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP		2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT		3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP		4	4
5 INVESTMENT INCOME-OTHER						5
6 TRADE, QUANTITY, AND TIME DISCOUNTS						6
7 REFUNDS AND REBATES OF EXPENSES						7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-10882	NEW CAP REL COSTS-BLDG & FIXT		3	9 8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)						9
10 TELEVISION AND RADIO SERVICE						10
11 PARKING LOT						11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST					
	A-8-2	-568869				12
13 SALE OF SCRAP, WASTE, ETC.						13
14 RELATED ORGANIZATION TRANSACTIONS	WKST					
	A-8-1					14
15 LAUNDRY AND LINEN SERVICE						15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-45472	DIETARY		11	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						18
19 SALE OF DRUGS TO OTHER THAN PATIENTS						19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-2941	MEDICAL RECORDS & LIBRARY		17	20
21 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22 VENDING MACHINES						22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		RESPIRATORY THERAPY		49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		PHYSICAL THERAPY		50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST		HOME HEALTH AGENCY		71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF		89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT		1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP		2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT		3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP		4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS		20	33
34 PHYSICIANS' ASSISTANT						34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		OCCUPATIONAL THERAPY		51	35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST		SPEECH PATHOLOGY		52	36
37 CATERING	B	-15202	DIETARY		11	37
38						38
39 LOBBYING EXPENSE	A	-3437	ADMINISTRATIVE & GENERAL		6	39
40						40
41 MARKETING SALARIES	A	-7643	ADMINISTRATIVE & GENERAL		6	41
42 MARKETING EXPENSE	A	-103541	ADMINISTRATIVE & GENERAL		6	42
43 MARKETING BENEFITS	A	-585	ADMINISTRATIVE & GENERAL		6	43
44 MISCELLANEOUS REVENUE	B	-1067	ADMINISTRATIVE & GENERAL		6	44
45						45
46						46
47 CRNA SALARIES	A	-82744	ANESTHESIOLOGY		40	47
47.01 CRNA BENEFITS	A	-3434	EMPLOYEE BENEFITS		5	47.01
47.02 CRNA OTHER	A	-6128	ANESTHESIOLOGY		40	47.02
48						48
49						49
49.02 POB LAPSING SCHEDULE	A	8160	NEW CAP REL COSTS-BLDG & FIXT		3	9 49.02
50 TOTAL		-843785				50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ- USTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS					

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1					
2					
3					
4					
5					

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

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1		2		3	4	5	6	7	8	9
2	44	LABORATORY	AGGREGATE	8000	8000					
3	49	RESPIRATORY THERAPY	AGGREGATE	13323	13323					
4	61	EMERGENCY	AGGREGATE	949865	547546	402319				
101		TOTAL		971188	568869	402319				



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

WORKSHEET A-8-4  
 PARTS I & II

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					320	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE					45	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		539.00	1672.00			9
10	AHSEA		71.23	53.43			10
11	STANDARD TRAVEL ALLOWANCE	35.62	35.62	26.72			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					38393	15
16	ASSISTANTS					89335	16
17	SUBTOTAL ALLOWANCE AMOUNT					127728	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					127728	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					127728	23

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-4  
PARTS III & IV

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	11398	24
25	ASSISTANTS	1202	25
26	SUBTOTAL	12600	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	12600	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	12600	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE			
36	THERAPISTS		36
37	ASSISTANTS		37
38	SUBTOTAL		38
39	STANDARD TRAVEL EXPENSE		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS		40
41	ASSISTANTS		41
42	SUBTOTAL		42
43	OPTIONAL TRAVEL EXPENSE		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4  
PARTS V,VI & VII

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION						
	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL	
	1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD				47	
48	OVERTIME RATE				48	
49	TOTAL OVERTIME				49	
CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY				50	
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50				51	
DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT				52	
53	OVERTIME COST LIMITATION				53	
54	MAXIMUM OVERTIME COST				54	
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA				55	
56	OVERTIME ALLOWANCE				56	
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57	SALARY EQUIVALENCY AMOUNT				127728	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE				12600	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES					59
60	OVERTIME ALLOWANCE					60
61	EQUIPMENT COST					61
62	SUPPLIES					62
63	TOTAL ALLOWANCE				140328	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES				139260	64
65	EXCESS OVER LIMITATION					65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-4  
PARTS V,VI & VII

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	139260	66
67	TOTAL COST	139260	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-4  
PARTS I & II

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					140	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE					225	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		2382.00	183.00	2375.00		9
10	AHSEA		71.23	53.43	35.62		10
11	STANDARD TRAVEL ALLOWANCE	35.62	35.62	26.72			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					169670	15
16	ASSISTANTS					9778	16
17	SUBTOTAL ALLOWANCE AMOUNT					179448	17
18	AIDES					84598	18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					264046	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					264046	23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-4  
PARTS III & IV

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	4987	24
25	ASSISTANTS	6012	25
26	SUBTOTAL	10999	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	10999	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	10999	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE			
36	THERAPISTS		36
37	ASSISTANTS		37
38	SUBTOTAL		38
39	STANDARD TRAVEL EXPENSE		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS		40
41	ASSISTANTS		41
42	SUBTOTAL		42
43	OPTIONAL TRAVEL EXPENSE		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
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WORKSHEET A-8-4  
 PARTS V,VI & VII

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION					
	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47	OVERTIME HOURS WORKED				47
	DURING REPORTING PERIOD				
48	OVERTIME RATE				48
49	TOTAL OVERTIME				49
CALCULATION OF LIMIT					
50	PERCENTAGE OF OVERTIME				50
	HOURS BY CATEGORY				
51	ALLOCATION OF PROVIDER'S				51
	STANDARD WORKYEAR FOR ONE				
	FULL TIME EMPLOYEE TIMES				
	THE PERCENTAGES ON LINE 50				
DETERMINATION OF OVERTIME ALLOWANCE					
52	ADJUSTED HOURLY SALARY				52
	EQUIVALENCY AMOUNT				
53	OVERTIME COST LIMITATION				53
54	MAXIMUM OVERTIME COST				54
55	PORTION OF OVERTIME ALREADY				55
	INCLUDED IN HOURLY				
	COMPUTATION AT THE AHSEA				
56	OVERTIME ALLOWANCE				56
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT					
57	SALARY EQUIVALENCY AMOUNT				264046
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE				10999
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES				59
60	OVERTIME ALLOWANCE				60
61	EQUIPMENT COST				61
62	SUPPLIES				62
63	TOTAL ALLOWANCE				275045
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES				260552
65	EXCESS OVER LIMITATION				65

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
02/11/2010 11:52

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

WORKSHEET A-8-4  
PARTS V,VI & VII

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	260552	66
67	TOTAL COST	260552	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	640469	640469							3
4 NEW CAP REL COSTS-MVBLE EQUIP	530391		530391						4
5 EMPLOYEE BENEFITS	748579			748579					5
6 ADMINISTRATIVE & GENERAL	3254634	341629	282915	87982	3967160	3967160			6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	644875	36217	29992	19919	731003	235112	966115		8
9 LAUNDRY & LINEN SERVICE	97903	10305	8534		116742	37548	10626	164916	9
10 HOUSEKEEPING	312579	8229	6815	26576	354199	113921	8486		10
11 DIETARY	603466	32151	26625	35327	697569	224359	33153		11
12 CAFETERIA		5227	4328		9555	3073	5390		12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	12598	8514	7050	298	28460	9154	8779		14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY									16
17 MEDICAL RECORDS & LIBRARY	322306	10429	8636	29872	371243	119403	10754		17
18 SOCIAL SERVICE	54009	3719	3080	5333	66141	21273	3835		18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	787216	37255	30852	77533	932856	300034	38415	53871	25
34 SKILLED NURSING FACILITY	1503911			131037	1634948	525850	362339	75334	34
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	252257	19338	16014	15956	303565	97636	19940		37
40 ANESTHESIOLOGY	34597			3007	37604	12095			40
41 RADIOLOGY-DIAGNOSTIC	781954	44112	36531	37093	899690	289367	45487		41
44 LABORATORY	655764	16348	13538	31797	717447	230752	16857		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	54899	6055	5014	2342	68310	21971	6243		49
50 PHYSICAL THERAPY	458376	8266	6846	3812	477300	153514	8524		50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
55 MEDICAL SUPPLIES CHARGED TO PAT	745926	8946	7408		762280	245172	9225		55
56 DRUGS CHARGED TO PATIENTS	624161	3101	2568	6216	636046	204571	3198		56
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC	76807	8860	7337	2245	95249	30635	9136		60
61 EMERGENCY	1175816	20227	16751	70709	1283503	412813	20858		61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC	942189			84598	1026787	330246	123591		63.50
63.51 RHC II	67637			3618	71255	22918			63.51
63.52 RHC III	302330			26189	328519	105662			63.52
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
65 AMBULANCE SERVICES	402350			33001	435351	140022			65
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	16087999	628928	520834	734460	16052782	3887101	744836	129205	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		11541	9557		21098	6786	11900		96
99.01 ASSISTED LIVING FOUNDATION	213700			14119	227819	73273	209379	35711	99.01
100 FOUNDATION									100
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	16301699	640469	530391	748579	16301699	3967160	966115	164916	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS
	10	11	12	14	17	18	25	26
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING	476606							10
11 DIETARY	16685	971766						11
12 CAFETERIA	2712	153988	174718					12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION	4418			50811				14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY	5412		8903		515715			17
18 SOCIAL SERVICE	1930		1991			95170		18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	19334	61100	21991	18380	102476	23793	1572250	25
34 SKILLED NURSING FACILITY	182358	536395	56316	8268	30266	66618	3478692	34
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	10035		10682	9110	34079		485047	37
40 ANESTHESIOLOGY			1313				51012	40
41 RADIOLOGY-DIAGNOSTIC	22892		8598		81027		1347061	41
44 LABORATORY	8484		9645		57196		1040381	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY	3142		764		47663		148093	49
50 PHYSICAL THERAPY	4290		6108		25023		674759	50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
55 MEDICAL SUPPLIES CHARGED TO PAT	4643						1021320	55
56 DRUGS CHARGED TO PATIENTS	1610		2024				847449	56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC	4598		627				140245	60
61 EMERGENCY	10497		22274	15053	99616	4759	1869373	61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC	62201		16883		37177		1596885	63.50
63.51 RHC II							94173	63.51
63.52 RHC III							434181	63.52
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES					1192		576565	65
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	365241	751483	168119	50811	515715	95170	15377486	95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN	5989						45773	96
99.01 ASSISTED LIVING	105376	220283	6599				878440	99.01
100 FOUNDATION								100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	476606	971766	174718	50811	515715	95170	16301699	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		TOTAL	
		27	
GENERAL SERVICE COST CENTERS			
1	OLD CAP REL COSTS-BLDG & FIXT		1
2	OLD CAP REL COSTS-MVBLE EQUIP		2
3	NEW CAP REL COSTS-BLDG & FIXT		3
4	NEW CAP REL COSTS-MVBLE EQUIP		4
5	EMPLOYEE BENEFITS		5
6	ADMINISTRATIVE & GENERAL		6
7	MAINTENANCE & REPAIRS		7
8	OPERATION OF PLANT		8
9	LAUNDRY & LINEN SERVICE		9
10	HOUSEKEEPING		10
11	DIETARY		11
12	CAFETERIA		12
13	MAINTENANCE OF PERSONNEL		13
14	NURSING ADMINISTRATION		14
15	CENTRAL SERVICES & SUPPLY		15
16	PHARMACY		16
17	MEDICAL RECORDS & LIBRARY		17
18	SOCIAL SERVICE		18
20	NONPHYSICIAN ANESTHETISTS		20
21	NURSING SCHOOL		21
22	I&R SERVICES-SALARY & FRINGES A		22
23	I&R SERVICES-OTHER PRGM COSTS A		23
24	PARAMED ED PRGM-(SPECIFY)		24
INPATIENT ROUTINE SERV COST CENTERS			
25	ADULTS & PEDIATRICS	1572250	25
34	SKILLED NURSING FACILITY	3478692	34
ANCILLARY SERVICE COST CENTERS			
37	OPERATING ROOM	485047	37
40	ANESTHESIOLOGY	51012	40
41	RADIOLOGY-DIAGNOSTIC	1347061	41
44	LABORATORY	1040381	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO		46.30
49	RESPIRATORY THERAPY	148093	49
50	PHYSICAL THERAPY	674759	50
51	OCCUPATIONAL THERAPY		51
52	SPEECH PATHOLOGY		52
55	MEDICAL SUPPLIES CHARGED TO PAT	1021320	55
56	DRUGS CHARGED TO PATIENTS	847449	56
OUTPATIENT SERVICE COST CENTERS			
60	CLINIC	140245	60
61	EMERGENCY	1869373	61
62	OBSERVATION BEDS (NON-DISTINCT)		62
63.50	RHC	1596885	63.50
63.51	RHC II	94173	63.51
63.52	RHC III	434181	63.52
63.60	FQHC		63.60
OTHER REIMBURSABLE COST CENTERS			
65	AMBULANCE SERVICES	576565	65
69.10	CMHC		69.10
69.20	OUTPATIENT PHYSICAL THERAPY		69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY		69.30
69.40	OUTPATIENT SPEECH PATHOLOGY		69.40
71	HOME HEALTH AGENCY		71
SPECIAL PURPOSE COST CENTERS			
85.01	PANCREAS ACQUISITION		85.01
85.02	INTESTINAL ACQUISITION		85.02
85.03	ISLET CELL ACQUISITION		85.03
95	SUBTOTALS	15377486	95
NONREIMBURSABLE COST CENTERS			
96	GIFT, FLOWER, COFFEE SHOP & CAN	45773	96
99.01	ASSISTED LIVING	878440	99.01
100	FOUNDATION		100
101	CROSS FOOT ADJUSTMENTS		101
102	NEGATIVE COST CENTER		102
103	TOTAL	16301699	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	ADMINIS- TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6 ADMINISTRATIVE & GENERAL		341629	282915	624544	624544				6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT		36217	29992	66209	37014	103223			8
9 LAUNDRY & LINEN SERVICE		10305	8534	18839	5911	1135	25885		9
10 HOUSEKEEPING		8229	6815	15044	17935	907		33886	10
11 DIETARY		32151	26625	58776	35321	3542		1186	11
12 CAFETERIA		5227	4328	9555	484	576		193	12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION		8514	7050	15564	1441	938		314	14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY									16
17 MEDICAL RECORDS & LIBRARY		10429	8636	19065	18798	1149		385	17
18 SOCIAL SERVICE		3719	3080	6799	3349	410		137	18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS		37255	30852	68107	47234	4104	8456	1375	25
34 SKILLED NURSING FACILITY					82779	38713	11824	12966	34
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		19338	16014	35352	15371	2130		714	37
40 ANESTHESIOLOGY					1904				40
41 RADIOLOGY-DIAGNOSTIC		44112	36531	80643	45555	4860		1628	41
44 LABORATORY		16348	13538	29886	36327	1801		603	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY		6055	5014	11069	3459	667		223	49
50 PHYSICAL THERAPY		8266	6846	15112	24168	911		305	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
55 MEDICAL SUPPLIES CHARGED TO PAT		8946	7408	16354	38597	986		330	55
56 DRUGS CHARGED TO PATIENTS		3101	2568	5669	32206	342		114	56
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC		8860	7337	16197	4823	976		327	60
61 EMERGENCY		20227	16751	36978	64989	2229		746	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC					51990	13205		4422	63.50
63.51 RHC II					3608				63.51
63.52 RHC III					16634				63.52
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
65 AMBULANCE SERVICES					22044				65
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS		628928	520834	1149762	611941	79581	20280	25968	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		11541	9557	21098	1068	1271		426	96
99.01 ASSISTED LIVING					11535	22371	5605	7492	99.01
100 FOUNDATION									100
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL		640469	530391	1170860	624544	103223	25885	33886	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	11	12	14	17	18		26	
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING								10
11 DIETARY	98825							11
12 CAFETERIA	15660	26468						12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION			18257					14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY		1349		40746				17
18 SOCIAL SERVICE		302			10997			18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	6214	3331	6604	8096	2749	156270		156270 25
34 SKILLED NURSING FACILITY	54549	8531	2971	2391	7698	222422		222422 34
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		1618	3273	2693		61151		61151 37
40 ANESTHESIOLOGY		199				2103		2103 40
41 RADIOLOGY-DIAGNOSTIC		1302		6402		140390		140390 41
44 LABORATORY		1461		4519		74597		74597 44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY		116		3766		19300		19300 49
50 PHYSICAL THERAPY		925		1977		43398		43398 50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
55 MEDICAL SUPPLIES CHARGED TO PAT						56267		56267 55
56 DRUGS CHARGED TO PATIENTS		307				38638		38638 56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		95				22418		22418 60
61 EMERGENCY		3374	5409	7871	550	122146		122146 61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC		2558		2937		75112		75112 63.50
63.51 RHC II						3608		3608 63.51
63.52 RHC III						16634		16634 63.52
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES				94		22138		22138 65
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	76423	25468	18257	40746	10997	1076592		1076592 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN						23863		23863 96
99.01 ASSISTED LIVING	22402	1000				70405		70405 99.01
100 FOUNDATION								100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	98825	26468	18257	40746	10997	1170860		1170860 103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP	NEW CAP	EMPLOYEE	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT SQUARE FEET	GROSS SALARIES		6A	6	8
	3	4	5				
GENERAL SERVICE COST CENTERS							
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	51833						3
4 NEW CAP REL COSTS-MVBLE EQUIP		51833					4
5 EMPLOYEE BENEFITS			6940511				5
6 ADMINISTRATIVE & GENERAL	27648	27648	815736	-3967160	12334539		6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	2931	2931	184680		731003	75825	8
9 LAUNDRY & LINEN SERVICE	834	834			116742	834	250616 9
10 HOUSEKEEPING	666	666	246401		354199	666	10
11 DIETARY	2602	2602	327541		697569	2602	11
12 CAFETERIA	423	423			9555	423	12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION	689	689	2763		28460	689	14
15 CENTRAL SERVICES & SUPPLY							15
16 PHARMACY							16
17 MEDICAL RECORDS & LIBRARY	844	844	276958		371243	844	17
18 SOCIAL SERVICE	301	301	49443		66141	301	18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES							22
23 I&R SERVICES-OTHER PRGM COSTS							23
24 PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS							
25 ADULTS & PEDIATRICS	3015	3015	718856		932856	3015	81865 25
34 SKILLED NURSING FACILITY			1214896		1634948	28438	114482 34
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	1565	1565	147941		303565	1565	37
40 ANESTHESIOLOGY			27884		37604		40
41 RADIOLOGY-DIAGNOSTIC	3570	3570	343910		899690	3570	41
44 LABORATORY	1323	1323	294812		717447	1323	44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY	490	490	21711		68310	490	49
50 PHYSICAL THERAPY	669	669	35346		477300	669	50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO P	724	724			762280	724	55
56 DRUGS CHARGED TO PATIENTS	251	251	57631		636046	251	56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC	717	717	20816		95249	717	60
61 EMERGENCY	1637	1637	655591		1283503	1637	61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC			784357		1026787	9700	63.50
63.51 RHC II			33542		71255		63.51
63.52 RHC III			242813		328519		63.52
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES			305976		435351		65
69.10 CMHC							69.10
69.20 OUTPATIENT PHYSICAL THERAPY							69.20
69.30 OUTPATIENT OCCUPATIONAL THERA							69.30
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
95 SUBTOTALS	50899	50899	6809604	-3967160	12085622	58458	196347 95
NONREIMBURSABLE COST CENTERS							
96 GIFT, FLOWER, COFFEE SHOP & C	934	934			21098	934	96
99.01 ASSISTED LIVING			130907		227819	16433	54269 99.01
100 FOUNDATION							100

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT SQUARE FEET 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON- CILIATION 6A	ADMINIS- TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	640469	530391	748579		3967160	966115	164916	103
104 UNIT COST MULT-WS B PT I		10.232690				12.741378		104
104 UNIT COST MULT-WS B PT I	12.356395		.107856		.321630		.658043	104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III					624544	103223	25885	107
108 UNIT COST MULT-WS B PT III						1.361332		108
108 UNIT COST MULT-WS B PT III					.050634		.103286	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	SQUARE FEET	MEALS SERVED	MEALS SERVED	DIRECT NRSING HRS	COSTED REQUIS.	COSTED REQUIS.	GROSS REVENUE	TIME SPENT
	10	11	12	14	15	16	17	18
GENERAL SERVICE COST CENTERS								
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10	HOUSEKEEPING	74325						10
11	DIETARY	2602	137478					11
12	CAFETERIA	423	21785	277145				12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION	689		60850				14
15	CENTRAL SERVICES & SUPPLY				100			15
16	PHARMACY					100		16
17	MEDICAL RECORDS & LIBRARY	844	14123				10820	17
18	SOCIAL SERVICE	301	3159					1000
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES							22
23	I&R SERVICES-OTHER PRGM COSTS							23
24	PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	3015	8644	34883	22011		2150	250
34	SKILLED NURSING FACILITY	28438	75885	89329	9902		635	700
ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	1565		16945	10910		715	37
40	ANESTHESIOLOGY			2082				40
41	RADIOLOGY-DIAGNOSTIC	3570		13638			1700	41
44	LABORATORY	1323		15300			1200	44
46.30	BLOOD CLOTTING FACTORS ADMIN							46.30
49	RESPIRATORY THERAPY	490		1212			1000	49
50	PHYSICAL THERAPY	669		9689			525	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO P	724				100		55
56	DRUGS CHARGED TO PATIENTS	251		3211			100	56
OUTPATIENT SERVICE COST CENTERS								
60	CLINIC	717		994				60
61	EMERGENCY	1637		35332	18027		2090	50
62	OBSERVATION BEDS (NON-DISTINC							62
63.50	RHC	9700		26780			780	63.50
63.51	RHC II							63.51
63.52	RHC III							63.52
63.60	FQHC							63.60
OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES						25	65
69.10	CMHC							69.10
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERA							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40
71	HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
95	SUBTOTALS	56958	106314	266677	60850	100	100	10820
NONREIMBURSABLE COST CENTERS								
96	GIFT, FLOWER, COFFEE SHOP & C	934						96
99.01	ASSISTED LIVING	16433	31164	10468				99.01
100	FOUNDATION							100

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	
	SQUARE FEET	MEALS SERVED	MEALS SERVED						
	10	11	12	14	15	16	17	18	
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 COST TO BE ALLOC PER B PT I	476606	971766	174718	50811			515715	95170	103
104 UNIT COST MULT-WS B PT I	6.412459		.630421				47.663124		104
104 UNIT COST MULT-WS B PT I		7.068520		.835021				95.170000	104
105 COST TO BE ALLOC PER B PT II									105
106 UNIT COST MULT-WS B PT II									106
106 UNIT COST MULT-WS B PT II									106
107 COST TO BE ALLOC PER B PT III	33886	98825	26468	18257			40746	10997	107
108 UNIT COST MULT-WS B PT III	.455917		.095502				3.765804		108
108 UNIT COST MULT-WS B PT III		.718842		.300033				10.997000	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

GENERAL SERVICE COST CENTERS		
1	OLD CAP REL COSTS-BLDG & FIXT	1
2	OLD CAP REL COSTS-MVBLE EQUIP	2
3	NEW CAP REL COSTS-BLDG & FIXT	3
4	NEW CAP REL COSTS-MVBLE EQUIP	4
5	EMPLOYEE BENEFITS	5
6	ADMINISTRATIVE & GENERAL	6
7	MAINTENANCE & REPAIRS	7
8	OPERATION OF PLANT	8
9	LAUNDRY & LINEN SERVICE	9
10	HOUSEKEEPING	10
11	DIETARY	11
12	CAFETERIA	12
13	MAINTENANCE OF PERSONNEL	13
14	NURSING ADMINISTRATION	14
15	CENTRAL SERVICES & SUPPLY	15
16	PHARMACY	16
17	MEDICAL RECORDS & LIBRARY	17
18	SOCIAL SERVICE	18
20	NONPHYSICIAN ANESTHETISTS	20
21	NURSING SCHOOL	21
22	I&R SERVICES-SALARY & FRINGES	22
23	I&R SERVICES-OTHER PRGM COSTS	23
24	PARAMED ED PRGM-(SPECIFY)	24
INPATIENT ROUTINE SERV COST CENTERS		
25	ADULTS & PEDIATRICS	25
34	SKILLED NURSING FACILITY	34
ANCILLARY SERVICE COST CENTERS		
37	OPERATING ROOM	37
40	ANESTHESIOLOGY	40
41	RADIOLOGY-DIAGNOSTIC	41
44	LABORATORY	44
46.30	BLOOD CLOTTING FACTORS ADMIN	46.30
49	RESPIRATORY THERAPY	49
50	PHYSICAL THERAPY	50
51	OCCUPATIONAL THERAPY	51
52	SPEECH PATHOLOGY	52
55	MEDICAL SUPPLIES CHARGED TO P	55
56	DRUGS CHARGED TO PATIENTS	56
OUTPATIENT SERVICE COST CENTERS		
60	CLINIC	60
61	EMERGENCY	61
62	OBSERVATION BEDS (NON-DISTINC	62
63.50	RHC	63.50
63.51	RHC II	63.51
63.52	RHC III	63.52
63.60	FQHC	63.60
OTHER REIMBURSABLE COST CENTERS		
65	AMBULANCE SERVICES	65
69.10	CMHC	69.10
69.20	OUTPATIENT PHYSICAL THERAPY	69.20
69.30	OUTPATIENT OCCUPATIONAL THERA	69.30
69.40	OUTPATIENT SPEECH PATHOLOGY	69.40
71	HOME HEALTH AGENCY	71
SPECIAL PURPOSE COST CENTERS		
85.01	PANCREAS ACQUISITION	85.01
85.02	INTESTINAL ACQUISITION	85.02
85.03	ISLET CELL ACQUISITION	85.03
95	SUBTOTALS	95
NONREIMBURSABLE COST CENTERS		
96	GIFT, FLOWER, COFFEE SHOP & C	96
99.01	ASSISTED LIVING	99.01
100	FOUNDATION	100

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (9/97)

VERSION: 2009.08  
02/11/2010 11:52

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

101	CROSS FOOT ADJUSTMENTS	101
102	NEGATIVE COST CENTER	102
103	COST TO BE ALLOC PER B PT I	103
104	UNIT COST MULT-WS B PT I	104
104	UNIT COST MULT-WS B PT I	104
105	COST TO BE ALLOC PER B PT II	105
106	UNIT COST MULT-WS B PT II	106
106	UNIT COST MULT-WS B PT II	106
107	COST TO BE ALLOC PER B PT III	107
108	UNIT COST MULT-WS B PT III	108
108	UNIT COST MULT-WS B PT III	108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	1572250		1572250		1572250	25
34 SKILLED NURSING FACILITY	3478692		3478692		3478692	34
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	485047		485047		485047	37
40 ANESTHESIOLOGY	51012		51012		51012	40
41 RADIOLOGY-DIAGNOSTIC	1347061		1347061		1347061	41
44 LABORATORY	1040381		1040381		1040381	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	148093		148093		148093	49
50 PHYSICAL THERAPY	674759		674759		674759	50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
55 MEDICAL SUPPLIES CHARGED TO	1021320		1021320		1021320	55
56 DRUGS CHARGED TO PATIENTS	847449		847449		847449	56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	140245		140245		140245	60
61 EMERGENCY	1869373		1869373		1869373	61
62 OBSERVATION BEDS (NON-DISTI	41220		41220		41220	62
63.50 RHC	1596885		1596885		1596885	63.50
63.51 RHC II	94173		94173		94173	63.51
63.52 RHC III	434181		434181		434181	63.52
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES	576565		576565		576565	65
101 SUBTOTAL	15418706		15418706		15418706	101
102 LESS OBSERVATION BEDS	41220		41220		41220	102
103 TOTAL	15377486		15377486		15377486	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	2049904		2049904			25
34 SKILLED NURSING FACILITY	3862368		3862368			34
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	172488	4331554	4504042	.107691	.107691	.107691 37
40 ANESTHESIOLOGY	22407	1147642	1170049	.043598	.043598	.043598 40
41 RADIOLOGY-DIAGNOSTIC	470442	6307135	6777577	.198753	.198753	.198753 41
44 LABORATORY	738575	3939656	4678231	.222388	.222388	.222388 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	416675	854840	1271515	.116470	.116470	.116470 49
50 PHYSICAL THERAPY	1040916	869493	1910409	.353201	.353201	.353201 50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
55 MEDICAL SUPPLIES CHARGED TO	842102	624210	1466312	.696523	.696523	.696523 55
56 DRUGS CHARGED TO PATIENTS	1774075	2459158	4233233	.200190	.200190	.200190 56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC		12600	12600	11.130556	11.130556	11.130556 60
61 EMERGENCY	280458	4793072	5073530	.368456	.368456	.368456 61
62 OBSERVATION BEDS (NON-DISTI		135976	135976	.303142	.303142	.303142 62
63.50 RHC		1690659	1690659	.944534	.944534	.944534 63.50
63.51 RHC II		119667	119667	.786959	.786959	.786959 63.51
63.52 RHC III		451805	451805	.960992	.960992	.960992 63.52
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES		1447934	1447934	.398198	.398198	.398198 65
101 SUBTOTAL	11670410	29185401	40855811			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	11670410	29185401	40855811			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1316) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	.107691	.107691	.107691			37
40 ANESTHESIOLOGY	.043598	.043598	.043598			40
41 RADIOLOGY-DIAGNOSTIC	.198753	.198753	.198753			41
44 LABORATORY	.222388	.222388	.222388			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	.116470	.116470	.116470			49
50 PHYSICAL THERAPY	.353201	.353201	.353201			50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
55 MEDICAL SUPPLIES CHARGED TO PAT	.696523	.696523	.696523			55
56 DRUGS CHARGED TO PATIENTS	.200190	.200190	.200190			56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	11.130556	11.130556	11.130556			60
61 EMERGENCY	.368456	.368456	.368456			61
62 OBSERVATION BEDS (NON-DISTINCT)	.303142	.303142	.303142			62
63.50 RHC	.944534	.944534	.944534			63.50
63.51 RHC II	.786959	.786959	.786959			63.51
63.52 RHC III	.960992	.960992	.960992			63.52
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES	.398198	.398198	.398198			65
65.01 AMBULANCE SERVICES (2ND PERIOD)	.398198	.398198	.398198			65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)	.398198	.398198	.398198			65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)	.398198	.398198	.398198			65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	1	
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)	.200190	1
2.01 VACCINE CHARGES - HEPATITIS B		2
3 VACCINE COSTS (OTHER THAN HEPATITIS B)		2.01
3.01 VACCINE COSTS - HEPATITIS B		3
		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1316) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
	ALL OTHER (1) (SEE INSTRU.)	PPS SER-VICES (SEE INSTRU.)	ALL OTHER (SEE INSTRU.)	PPS SER-VICES (SEE INSTRU.)	PPS SER-VICES (SEE INSTRU.)	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC
	5	5.01	5.02	5.03	5.04	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	2067788							37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC	1741670							41
44 LABORATORY	1362133							44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY	402306							49
50 PHYSICAL THERAPY	354325							50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
55 MEDICAL SUPPLIES CHARGED TO PA	486498							55
56 DRUGS CHARGED TO PATIENTS	571588							56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC	7050							60
61 EMERGENCY	1333948							61
62 OBSERVATION BEDS (NON-DISTINCT	49418							62
63.50 RHC								63.50
63.51 RHC II								63.51
63.52 RHC III								63.52
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES								65
65.01 AMBULANCE SERVICES (2ND PERIOD								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD								65.02
65.03 AMBULANCE SERVICES (4TH PERIOD								65.03
101 SUBTOTAL	8376724							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	8376724							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1316) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL I/P PART B CHARGES (SEE INSTRU.)	HOSPITAL I/P PART B COST (COLUMNS 1.02x10)
	ALL OTHER (COLS 1x5) 9	PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS 1.01x5.03) 9.03		
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	222682					37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	346162					41
44 LABORATORY	302922					44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	46857					49
50 PHYSICAL THERAPY	125148					50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
55 MEDICAL SUPPLIES CHARGED TO PAT	338857					55
56 DRUGS CHARGED TO PATIENTS	114426					56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	78470					60
61 EMERGENCY	491501					61
62 OBSERVATION BEDS (NON-DISTINCT)	14981					62
63.50 RHC						63.50
63.51 RHC II						63.51
63.52 RHC III						63.52
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES						65
65.01 AMBULANCE SERVICES (2ND PERIOD)						65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)						65.02
65.03 AMBULANCE SERVICES (4TH PERIOD)						65.03
101 SUBTOTAL	2082006					101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES	2082006					104

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2009.08  
 02/11/2010 11:52

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[XX]	SNF (14-5470)	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF		
			[ ]	SUB III	[ ]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.51 RHC II							63.51
63.52 RHC III							63.52
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [XX] SNF (14-5470) [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	PROGRAM
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	PASS THROUGH	PROGRAM
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		4504042					37
40 ANESTHESIOLOGY		1170049					40
41 RADIOLOGY-DIAGNOSTIC		6777577			8328		41
44 LABORATORY		4678231			9646		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		1271515			3650		49
50 PHYSICAL THERAPY		1910409			149782		50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO P		1466312			8969		55
56 DRUGS CHARGED TO PATIENTS		4233233			101566		56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		12600					60
61 EMERGENCY		5073530					61
62 OBSERVATION BEDS (NON-DISTINC		135976					62
63.50 RHC		1690659					63.50
63.51 RHC II		119667					63.51
63.52 RHC III		451805					63.52
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL		31233474			281941		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[XX]	SNF (14-5470)	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF		
			[ ]	SUB III	[ ]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.51 RHC II					63.51
63.52 RHC III					63.52
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
101 TOTAL	8.01	8.02	9	9.01	101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	OLD CAPITAL		NEW CAPITAL		
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	
	1	2	3	4	
INPAT ROUTINE SERV COST CTRS					
25 ADULTS & PEDIATRICS				156270	25
26 INTENSIVE CARE UNIT				80191	26
27 CORONARY CARE UNIT					27
28 BURN INTENSIVE CARE UNIT					28
29 SURGICAL INTENSIVE CARE UNIT					29
30 OTHER SPECIAL CARE (SPECIFY)					30
31 SUBPROVIDER I					31
33 NURSERY					33
101 TOTAL				156270	101
					76079

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST	
	7	8	9	10	11	12	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS	1207	62			63.03	3908	25
26 INTENSIVE CARE UNIT							26
27 CORONARY CARE UNIT							27
28 BURN INTENSIVE CARE UNIT							28
29 SURGICAL INTENSIVE CARE UNIT							29
30 OTHER SPECIAL CARE (SPECIFY)							30
31 SUBPROVIDER I							31
33 NURSERY							33
101 TOTAL	1207	62				3908	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-1316) [ ] SUB III [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SUB IV [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [XX] OTHER

COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST	NEW CAPITAL RELATED COST	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES	CAPITAL COSTS	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES	CAPITAL COSTS
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		61151	4504042				.013577	37
40 ANESTHESIOLOGY		2103	1170049				.001797	40
41 RADIOLOGY-DIAGNOSTIC		140390	6777577				.020714	41
44 LABORATORY		74597	4678231				.015946	44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY		19300	1271515				.015179	49
50 PHYSICAL THERAPY		43398	1910409				.022717	50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
55 MEDICAL SUPPLIES CHARGED TO P		56267	1466312				.038373	55
56 DRUGS CHARGED TO PATIENTS		38638	4233233				.009127	56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC		22418	12600				1.779206	60
61 EMERGENCY		122146	5073530				.024075	61
62 OBSERVATION BEDS (NON-DISTINC			135976					62
63.50 RHC			1690659					63.50
63.51 RHC II			119667					63.51
63.52 RHC III			451805					63.52
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES								65
101 TOTAL		580408	31233474					101

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER	DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL	TOTAL	PER	INPATIENT	INPATIENT
		ANESTHETIST	EDUCATION	ADJUSTMENT	COSTS	PATIENT	DIEM	PROGRAM	PROGRAM
		COST	COST	AMOUNT		DAYS		DAYS	PASS THRU
		1	2	3	4	5	6	7	8
	INPAT ROUTINE SERV COST CTRS								
25	ADULTS & PEDIATRICS					1207		62	25
26	INTENSIVE CARE UNIT								26
27	CORONARY CARE UNIT								27
28	BURN INTENSIVE CARE UNIT								28
29	SURGICAL INTENSIVE CARE UNIT								29
30	OTHER SPECIAL CARE (SPECIFY)								30
31	SUBPROVIDER I								31
33	NURSERY								33
34	SKILLED NURSING FACILITY					27165			34
35	NURSING FACILITY								35
101	TOTAL					28372		62	101

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2009.08  
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
			[ ]	SUB III	[ ]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST COST	NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.51 RHC II							63.51
63.52 RHC III							63.52
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-1316) [ ] SUB IV [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] NF [ ] OTHER  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		4504042					37
40 ANESTHESIOLOGY		1170049					40
41 RADIOLOGY-DIAGNOSTIC		6777577					41
44 LABORATORY		4678231					44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		1271515					49
50 PHYSICAL THERAPY		1910409					50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO P		1466312					55
56 DRUGS CHARGED TO PATIENTS		4233233					56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		12600					60
61 EMERGENCY		5073530					61
62 OBSERVATION BEDS (NON-DISTINC		135976					62
63.50 RHC		1690659					63.50
63.51 RHC II		119667					63.51
63.52 RHC III		451805					63.52
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
101 TOTAL		31233474					101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-1316) [ ] SUB IV [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] NF [ ] OTHER  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.51 RHC II					63.51
63.52 RHC III					63.52
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
101 TOTAL	8.01	8.02	9	9.01	101

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF (PPS) (14-5470)	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3075					27165	1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1207					27165	2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1207					27165	4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	225						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	938						6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	190						7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	515						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	743					614	9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	225						10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	938						11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF (PPS) (14-5470)	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	96.62						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.89						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1572250					3478692	21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	18358						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	50928						25
26 TOTAL SWING-BED COST	806814						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	765436					3478692	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1422428					3403144	28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1422428					3403144	30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.538119					1.022199	31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1178.48					125.28	33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	765436					3478692	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	634.16					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	471181					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	471181					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						47
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	481680					48
49 TOTAL PROGRAM INPATIENT COSTS	952861					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	142686					60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	594842					61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	737528					62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

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

	SNF (PPS) (14-5470)	
	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST	3478692	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	128.06	67
68 PROGRAM ROUTINE SERVICE COST	78629	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	78629	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	222422	71
72 PER DIEM CAPITAL RELATED COSTS	8.19	72
73 PROGRAM CAPITAL RELATED COSTS	5029	73
74 INPATIENT ROUTINE SERVICE COST	73600	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	73600	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	78629	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	83707	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	162336	82

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	65	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	634.16	84
85 OBSERVATION BED COST	41220	85

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	NF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3075						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1207						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1207						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	225						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	938						6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	190						7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	515						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	62						9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13 SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	96.62						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.89						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1572250						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	18358						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	50928						25
26 TOTAL SWING-BED COST	806814						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	765436						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1422428						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1422428						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.538119						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1178.48						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	765436						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	634.16					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	39318					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	39318					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						47
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49 TOTAL PROGRAM INPATIENT COSTS	39318					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	3908					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST	3908					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY NF

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

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	65	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	634.16	84
85 OBSERVATION BED COST	41220	85



INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input checked="" type="checkbox"/> SNF (14-5470)	<input checked="" type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input type="checkbox"/> S/B-SNF	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.107691			37
40 ANESTHESIOLOGY	.043598			40
41 RADIOLOGY-DIAGNOSTIC	.198753	8328	1655	41
44 LABORATORY	.222388	9646	2145	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.116470	3650	425	49
50 PHYSICAL THERAPY	.353201	149782	52903	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
55 MEDICAL SUPPLIES CHARGED TO PAT	.696523	8969	6247	55
56 DRUGS CHARGED TO PATIENTS	.200190	101566	20332	56
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	11.130556			60
61 EMERGENCY	.368456			61
62 OBSERVATION BEDS (NON-DISTINCT	.303142			62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	.944534			63.50
63.51 RHC II	.786959			63.51
63.52 RHC III	.960992			63.52
63.60 FQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		281941	83707	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		281941		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input checked="" type="checkbox"/> S/B-SNF (14-Z316)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.107691			37
40 ANESTHESIOLOGY	.043598			40
41 RADIOLOGY-DIAGNOSTIC	.198753	22973	4566	41
44 LABORATORY	.222388	45059	10021	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.116470	75800	8828	49
50 PHYSICAL THERAPY	.353201	523181	184788	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
55 MEDICAL SUPPLIES CHARGED TO PAT	.696523	147410	102674	55
56 DRUGS CHARGED TO PATIENTS	.200190	356136	71295	56
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	11.130556			60
61 EMERGENCY	.368456			61
62 OBSERVATION BEDS (NON-DISTINCT	.303142			62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	.944534			63.50
63.51 RHC II	.786959			63.51
63.52 RHC III	.960992			63.52
63.60 FQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		1170559	382172	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		1170559		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V                                    [XX] HOSPITAL (14-1316)                    [ ] SNF                                    [ ] PPS  
 [ ] TITLE XVIII-PT A                        [ ] SUB I                                    [ ] NF                                    [ ] TEFRA  
 [XX] TITLE XIX                                [ ] SUB II                                  [ ] S/B-SNF                              [XX] OTHER  
    [ ] SUB III                                [ ] S/B-NF  
    [ ] SUB IV                                [ ] ICF/MR

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	3
INPATIENT ROUTINE SERVICE COST CENTERS			
25 ADULTS & PEDIATRICS			25
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	.107691		37
40 ANESTHESIOLOGY	.043598		40
41 RADIOLOGY-DIAGNOSTIC	.198753		41
44 LABORATORY	.222388		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO			46.30
49 RESPIRATORY THERAPY	.116470		49
50 PHYSICAL THERAPY	.353201		50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY			52
55 MEDICAL SUPPLIES CHARGED TO PAT	.696523		55
56 DRUGS CHARGED TO PATIENTS	.200190		56
OUTPATIENT SERVICE COST CENTERS			
60 CLINIC	11.130556		60
61 EMERGENCY	.368456		61
62 OBSERVATION BEDS (NON-DISTINCT	.303142		62
OTHER REIMBURSABLE COST CENTERS			
63.50 RHC	.944534		63.50
63.51 RHC II	.786959		63.51
63.52 RHC III	.960992		63.52
63.60 FQHC			63.60
65 AMBULANCE SERVICES			65
101 TOTAL			101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES			102
103 NET CHARGES			103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL	SUB I	SUB II	SUB III	SUB IV
DRG AMOUNT				
1				1
1.01				1.01
1.02				1.02
1.03				1.03
1.04				1.04
1.05				1.05
1.06				1.06
1.07				1.07
1.08				1.08
2				2
2.01				2.01
3				3
3.01				3.01
3.02				3.02
3.03				3.03
3.04				3.04
3.05				3.05
3.06				3.06
3.07				3.07
3.08				3.08
3.09				3.09
3.10				3.10
3.11				3.11
3.12				3.12
3.13				3.13
3.14				3.14
3.15				3.15
3.16				3.16
3.17				3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A  
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
3.18						3.18
3.19						3.19
3.20						3.20
3.21						3.21
3.22						3.22
3.23						3.23
3.24						3.24
4						4
4.01						4.01
4.02						4.02
4.03						4.03
4.04						4.04
5						5
5.01						5.01
5.02						5.02
5.03						5.03
5.04						5.04
5.05						5.05
5.06						5.06
6						6
7						7
7.01						7.01
8						8
9						9
10						10
11						11
11.01						11.01
11.02						11.02
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
21.01						21.01
21.02						21.02
22						22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A  
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23						23
						TERMINATION OR A DECREASE IN PROGRAM UTILIZATION
24						24
						OTHER ADJUSTMENTS
25						25
						AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS
26						26
						AMOUNT DUE PROVIDER
27						27
						SEQUESTRATION ADJUSTMENT
28						28
						INTERIM PAYMENTS
28.01						28.01
						TENTATIVE SETTLEMENT (FOR FI USE ONLY)
29						29
						BALANCE DUE PROVIDER (PROGRAM)
30						30
						PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2
						TO BE COMPLETED BY INTERMEDIARY
50						50
						OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01
51						51
						CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01
52						52
						OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTR.)
53						53
						CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
54						54
						THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
55						55
						TIME VALUE OF MONEY (SEE INSTRUCTIONS)
56						56
						CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1316) 1	HOSPITAL (14-1316) 1.01	HOSPITAL (14-1316) 1.02	
1 MEDICAL AND OTHER SERVICES	2082006			1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST	2082006			5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES				10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
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)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES	2102826			17
17.01 TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1316) 1	HOSPITAL (14-1316) 1.01	HOSPITAL (14-1316) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	15493		18
18.01 COINSURANCE	1402268		18.01
19 SUBTOTAL	685065		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	685065		23
24 PRIMARY PAYER PAYMENTS			24
25 SUBTOTAL	685065		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	373734		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	373734		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	351241		27.02
28 SUBTOTAL	1058799		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	1058799		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	805887		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	252912		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	SNF (14-5470)	SNF (14-5470)	SNF (14-5470)	
	1	1.01	1.02	
1 MEDICAL AND OTHER SERVICES				1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST				5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES				10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
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)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES				17
17.01 TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	SNF (14-5470)	SNF (14-5470)	SNF (14-5470)	
	1	1.01	1.02	
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18				18
18.01				18.01
19				19
20				20
21				21
22				22
23				23
24				24
25				25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26				26
27				27
27.01				27.01
27.02				27.02
28				28
29				29
RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				
30				30
30.99				30.99
31				31
AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				
32				32
33				33
34				34
34.01				34.01
35				35
36				36
PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				
TO BE COMPLETED BY CONTRACTOR				
50				50
51				51
52				52
53				53
54				54

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[ ] TITLE V            [XX] TITLE XVIII            [ ] TITLE XIX

HOSPITAL  
(14-1316)  
OCTOBER 1, 1997  
PRIOR TO    ON OR AFTER  
1            1.01

1	STANDARD OVERHEAD AMOUNTS (ASC FEES)	1
2	DEDUCTIBLES	2
3	SUBTOTAL	3
4	80 PERCENT OF LINE 3	4
5	ASC PORTION OF BLEND	5
6	OUTPATIENT ASC COST	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	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)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	HOSPITAL SPECIFIC PORTION OF BLEND	17
18	ASC BLENDED AMOUNT	18
19	LESSER OF LINES 16 OR 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	ASC PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

HOSPITAL  
(14-1316)  
OCTOBER 1, 1997  
PRIOR TO ON OR AFTER  
1 1.01

1	PREVALLING CHARGES	1
2	62 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OUTPATIENT RADIOLOGY	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	RADIOLOGY PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

HOSPITAL  
(14-1316)  
OCTOBER 1, 1997  
PRIOR TO ON OR AFTER  
1 1.01

1	PREVALLING CHARGES	1
2	42 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	DIAGNOSTIC PAYMENT AMOUNT	21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 HOSPITAL (14-1316)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		584652		1378915	1
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	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	.01	04/03/2009		40431	3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02	09/04/2009		11806	3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03	09/14/2009		83520	3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .04				3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.05				3.05
	.50		04/03/2009	115666	3.50
	PROVIDER .51		09/04/2009	593119	3.51
	TO .52				3.52
	PROGRAM .53				3.53
	.54				3.54
SUBTOTAL	.99	131295		-573028	3.99
4 TOTAL INTERIM PAYMENTS		715947		805887	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- PROGRAM .01					5.01
MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH TO .02		NONE		NONE	5.02
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. PROVIDER .03					5.03
	PROVIDER .50				5.50
	TO .51			NONE	5.51
	PROGRAM .52				5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT PROGRAM TO					
(BALANCE DUE) BASED ON THE COST PROVIDER .01		80425		252912	6.01
REPORT. PROVIDER TO .02					6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		796372		1058799	7
NAME OF INTERMEDIARY: _____			INTERMEDIARY NUMBER: _____		
SIGNATURE OF AUTHORIZED PERSON: _____			DATE (MO/DAY/YR): _____		

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 SKILLED NURSING FACILITY I (14-5470)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		164668		1
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		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	.01			3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02			3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03			3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .04	NONE		3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.05			3.05
	.50			3.50
	PROVIDER .51			3.51
	TO .52	NONE		3.52
	PROGRAM .53		NONE	3.53
	.54			3.54
SUBTOTAL	.99			3.99
4 TOTAL INTERIM PAYMENTS		164668		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02	NONE		5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51	NONE		5.51
	PROGRAM .52			5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	7057		6.01
	PROVIDER TO .02			6.02
PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		171725		7

NAME OF INTERMEDIARY: \_\_\_\_\_  
 SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

INTERMEDIARY NUMBER: \_\_\_\_\_  
 DATE (MO/DAY/YR): \_\_\_\_\_

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 SWING BED SKILLED NURSING FACILITY (14-Z316)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B	
	PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		885419		1
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	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	.01	04/03/2009		3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02	09/04/2009		3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03	09/18/2009		3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .04		NONE	3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.05			3.05
	.50			3.50
	PROVIDER .51			3.51
	TO .52	NONE	NONE	3.52
	PROGRAM .53			3.53
	.54			3.54
SUBTOTAL	.99	135046		3.99
4 TOTAL INTERIM PAYMENTS		1020465		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02	NONE	NONE	5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51	NONE	NONE	5.51
	PROGRAM .52			5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	70117		6.01
	PROVIDER TO .02			6.02
PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		1090582		7

NAME OF INTERMEDIARY: \_\_\_\_\_  
 SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

INTERMEDIARY NUMBER: \_\_\_\_\_  
 DATE (MO/DAY/YR): \_\_\_\_\_

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 SWING BEDS

SUPPLEMENTAL  
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V	--- TITLE XVIII ---		--- TITLE XIX ---		
	S/B NF	S/B SNF	S/B SNF	S/B SNF	S/B NF	
		PART A	PART B	(14-Z316)		
	1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		744903			1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES		385994			3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS		1163			5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL		1130897			8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL		1130897			10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL		1130897			12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		40315			13
14	80% OF PART B COSTS					14
15	SUBTOTAL		1090582			15
16	OTHER ADJUSTMENTS					16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)					17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					17.01
18	TOTAL		1090582			18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS		1020465			20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM		70117			21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF I
1 INPATIENT SERVICES	952861					1
1.01 NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)						1.01
2 ORGAN ACQUISITION						2
3 COST OF TEACHING PHYSICIANS						3
4 SUBTOTAL	952861					4
5 PRIMARY PAYER PAYMENTS						5
6 TOTAL COST	962390					6
COMPUTATION OF LESSER OF COST OR CHARGES						
7 REASONABLE CHARGES						7
8 ROUTINE SERVICE CHARGES						8
9 ANCILLARY SERVICE CHARGES						9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE						10
11 TEACHING PHYSICIANS						11
12 TOTAL REASONABLE CHARGES						12
13 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS						13
14 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(E)						14
15 RATIO OF LINE 12 TO LINE 13						15
16 TOTAL CUSTOMARY CHARGES						16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						18

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
25.01						25.01
25.02						25.02
26						26
27						27
28						28
29						29
30						30
31						31
32						32
32.01						32.01
33						33
34						34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART III

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

	[ ] TITLE V	[XX] TITLE XVIII	[ ] TITLE XIX
		SNF I (14-5470) (PPS) 2	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
COMPUTATION OF LESSER OF COST OR CHARGES			
10			10
11			11
12			12
13			13
14			14
15			15
16			16
CUSTOMARY CHARGES			
17			17
18			18
19			19
20			20
21			21
22			22
23			23
PROSPECTIVE PAYMENT AMOUNT			
24		213486	24
25			25
26			26
27			27
28			28
29			29
30		213486	30
31			31
32		213486	32
33			33

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART III

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

	[ ] TITLE V	[XX] TITLE XVIII	[ ] TITLE XIX
		SNF I (14-5470) (PPS) 2	
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST		34
35	SUBTOTAL	213486	35
36	COINSURANCE	48817	36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E, LINE 19		37
38	REIMBURSABLE BAD DEBTS	7056	38
38.01	REDUCED REIMBURSABLE BAD DEBTS		38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	7056	38.02
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING ON OR AFTER 10/01/05 (SEE INSTR.)	7056	38.03
39	UTILIZATION REVIEW		39
40	SUBTOTAL	171725	40
41	INPATIENT ROUTINE SERVICE COST		41
42	MEDICARE INPATIENT ROUTINE CHARGES		42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		43
44	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)		44
45	RATIO OF LINE 43 TO LINE 44		45
46	TOTAL CUSTOMARY CHARGES		46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		49
50	LOSS ON SALE OF ASSETS		50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		51
52	SUBTOTAL	171725	52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	171725	55
56	SEQUESTRATION ADJUSTMENT		56
57	INTERIM PAYMENTS	164668	57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)		57.01
58	BALANCE DUE PROVIDER/PROGRAM	7057	58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		59

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3  
 PART III

	[ ] TITLE V	[ ] TITLE XVIII	[XX] TITLE XIX			NF I (PPS)	
		HOSPITAL (14-1316) (OTHER)	SUB I	SUB II	SUB III	SUB IV	
1	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1
2	INPATIENT HOSPITAL/SNF/NF SERVICES	39318					2
3	MEDICAL AND OTHER SERVICES						3
4	INTERNS AND RESIDENTS						4
5	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O						5
6	COST OF TEACHING PHYSICIANS						6
7	SUBTOTAL	39318					7
8	INPATIENT PRIMARY PAYER PAYMENTS						8
9	OUTPATIENT PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL	39318					10
11	COMPUTATION OF LESSER OF COST OR CHARGES						11
12	ROUTINE SERVICE CHARGES						12
13	ANCILLARY SERVICE CHARGES						13
14	INTERNS AND RESIDENTS SERVICE CHARGES						14
15	ORGAN ACQUISITION CHARGES, NET OF REVENUE						15
16	TEACHING PHYSICIANS						16
17	INCENTIVE FROM TARGET AMOUNT COMPUTATION						17
18	TOTAL REASONABLE CHARGES						18
19	CUSTOMARY CHARGES						19
20	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						20
21	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM						21
22	A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN						22
23	ACCORDANCE WITH 42 CFR 413.13(E)						23
24	RATIO OF LINE 17 TO LINE 18						24
25	TOTAL CUSTOMARY CHARGES						25
26	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						26
27	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						27
28	COST OF COVERED SERVICES	39318					28
29	PROSPECTIVE PAYMENT AMOUNT						29
30	OTHER THAN OUTLIER PAYMENTS						30
31	OUTLIER PAYMENTS						31
32	PROGRAM CAPITAL PAYMENTS						32
33	CAPITAL EXCEPTION PAYMENTS						33
34	ROUTINE SERVICE OTHER PASS THROUGH COSTS						34
35	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						35
36	SUBTOTAL	39318					36
37	CUSTOMARY CHARGES (TITLE XIX PPS COVERED)						37
38	LESSER OF LINES 30 OR 31	39318					38
39	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)						39

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3  
 PART III

	[ ] TITLE V	[ ] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (14-1316) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
		1	1	1	1	1	1
COMPUTATION OF REIMBURSEMENT SETTLEMENT							
34	EXCESS OF REASONABLE COST						34
35	SUBTOTAL	39318					35
36	COINSURANCE						36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,						37
38	REIMBURSABLE BAD DEBTS						38
38.01	REDUCED REIMBURSABLE BAD DEBTS						38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)						38.02
39	UTILIZATION REVIEW						39
40	SUBTOTAL	39318					40
41	INPATIENT ROUTINE SERVICE COST						41
42	MEDICARE INPATIENT ROUTINE CHARGES						42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						44
45	RATIO OF LINE 43 TO LINE 44						45
46	TOTAL CUSTOMARY CHARGES						46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION						49
50	LOSS ON SALE OF ASSETS						50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS						51
52	SUBTOTAL	39318					52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT						53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	39318					55
56	SEQUESTRATION ADJUSTMENT						56
57	INTERIM PAYMENTS						57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						57.01
58	BALANCE DUE PROVIDER/PROGRAM	39318					58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2)						59

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	776428			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6121893			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4298848			6
7	INVENTORY	217051			7
8	PREPAID EXPENSES	52344			8
9	OTHER CURRENT ASSETS	225251			9
10	DUE FROM OTHER FUNDS	-102162			10
11	TOTAL CURRENT ASSETS	2991957			11
FIXED ASSETS					
12	LAND	264490			12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS				13
13.01	ACCUMULATED DEPRECIATION				13.01
14	BUILDINGS	10209049			14
14.01	ACCUMULATED DEPRECIATION	-3450181			14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT				16
16.01	ACCUMULATED DEPRECIATION				16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	3987993			18
18.01	ACCUMULATED DEPRECIATION	-2554400			18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	8456951			21
OTHER ASSETS					
22	INVESTMENTS	4444486			22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	1106935			25
26	TOTAL OTHER ASSETS	5551421			26
27	TOTAL ASSETS	17000329			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	855139			28
29	SALARIES, WAGES & FEES PAYABLE	858217			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)				31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES	1252672			35
36	TOTAL CURRENT LIABILITIES	2966028			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE	7450000			37
38	NOTES PAYABLE				38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES	814676			41
42	TOTAL LONG TERM LIABILITIES	8264676			42
43	TOTAL LIABILITIES	11230704			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	5769625			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	5769625			51
52	TOTAL LIABILITIES AND FUND BALANCES	17000329			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	3838332			1
2 NET INCOME (LOSS)	1931293			2
3 TOTAL	5769625			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	5769625			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	5769625			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1425836		1425836	2
4 SUBPROVIDER I				4
5 SWING BED - SNF	702167		702167	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY	3865056		3865056	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES	5993059		5993059	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	5993059		5993059	18
19 ANCILLARY SERVICES	5834343	25360985	31195328	19
20 OUTPATIENT SERVICES				20
21 18.50 RHC		1690659	1690659	21
22 18.51 RHC II		119667	119667	22
23 18.52 RHC III		451805	451805	23
24 18.60 FQHC				24
25 HOME HEALTH AGENCY				25
26 AMBULANCE		1447934	1447934	26
27 CORF				27
28 ASC				28
29 HOSPICE				29
30 PROFESSIONAL FEES		155796	155796	30
31 TOTAL PATIENT REVENUES	11827402	29226846	41054248	31

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		17145484	26
27 ADD (SPECIFY)			27
28 BAD DEBTS	1787563		28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		1787563	33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		18933047	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	41054248	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	21160019	2
3	NET PATIENT REVENUES	19894229	3
4	LESS - TOTAL OPERATING EXPENSES	18933047	4
5	NET INCOME FROM SERVICE TO PATIENTS	961182	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	25914	6
7	INCOME FROM INVESTMENTS	105834	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	45472	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	2941	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	10882	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	TRUST INCOME		24
24.01	MISCELLANEOUS INCOME		24.01
24.02	UNREALIZED GAINS		24.02
24.03	GRANTS	144839	24.03
24.04	CATERING	15201	24.04
24.05	MEDICAID ASSESSMENT REVENUE	141728	24.05
24.06	COUNTY TERRACE	477300	24.06
25	TOTAL OTHER INCOME	970111	25
26	TOTAL	1931293	26
27	LOSS ON DISPOSAL		27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	1931293	31

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL 4A	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE					18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES					22
23 I&R SERVICES-OTHER PRGM COSTS					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS					25
34 SKILLED NURSING FACILITY					34
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN C					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
55 MEDICAL SUPPLIES CHARGED TO PA					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINCT					62
63.50 RHC					63.50
63.51 RHC II					63.51
63.52 RHC III					63.52
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
65 AMBULANCE SERVICES					65
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERAP					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03
95 SUBTOTALS					95
NONREIMBURSABLE COST CENTERS					
96 GIFT, FLOWER, COFFEE SHOP & CA					96
99.01 ASSISTED LIVING					99.01
100 FOUNDATION					100
101 CROSS FOOT ADJUSTMENTS					101
102 NEGATIVE COST CENTER					102
103 TOTAL					103
104 TOTAL STATISTICAL BASIS					104
105 UNIT COST MULTIPLIER					105
105 UNIT COST MULTIPLIER					105

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
 02/11/2010 11:52

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET M-1

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

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN								1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	855491	142321	997812	-55623	942189		942189	9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	855491	142321	997812	-55623	942189		942189	10
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS								14
15 MEDICAL SUPPLIES								15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)								21
22 TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES	855491	142321	997812	-55623	942189		942189	22
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS								30
31 TOTAL FACILITY OVERHEAD								31
32 TOTAL FACILITY COSTS	855491	142321	997812	-55623	942189		942189	32

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2009.08  
 02/11/2010 11:52

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1 PHYSICIANS	1.79	8661	4200	7518		1
2 PHYSICIAN ASSISTANTS	1.40	5160	2100	2940		2
3 NURSE PRACTITIONERS			2100			3
4 SUBTOTAL	3.19	13821		10458	13821	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	3.19	13821			13821	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					942189	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					942189	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD						14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					654696	15
16 TOTAL OVERHEAD					654696	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					654696	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					654696	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					1596885	20

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES			1596885	1
2	COST OF VACCINES AND THEIR ADMINISTRATION				2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE			1596885	3
4	TOTAL VISITS			13821	4
5	PHYSICIANS VISITS UNDER AGREEMENT				5
6	TOTAL ADJUSTED VISITS			13821	6
7	ADJUSTED COST PER VISIT			115.54	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT				8
9	RATE FOR PROGRAM COVERED VISITS	115.54	115.54		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	947	2322		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	109416	268284		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES				14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST				15
16	TOTAL PROGRAM COST			377700	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			30229	17
18	NET PROGRAM COST EXCLUDING VACCINES			347471	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			277977	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION				20
21	TOTAL REIMBURSABLE PROGRAM COST			277977	21
22	REIMBURSABLE BAD DEBTS				22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			277977	24
25	INTERIM PAYMENTS			312333	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			-34356	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				27

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

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	942189	942189	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME			2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST			3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE			4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE			5
6 TOTAL DIRECT COST OF THE FACILITY	942189	942189	6
7 TOTAL OVERHEAD	654696	654696	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST			8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE			9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION			10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS			11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION			12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES			13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			16

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
02/11/2010 11:52

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

RHC I  
COMPONENT NO: 14-3448

WORKSHEET M-5

CHECK [ XX ] RHC  
APPLICABLE BOX: [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		312333	1
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	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	PROGRAM .01		3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02		3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03	NONE	3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .04		3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.05		3.05
	.50		3.50
	PROVIDER .51		3.51
	TO .52	NONE	3.52
	PROGRAM .53		3.53
	.54		3.54
SUBTOTAL	.99		3.99
4 TOTAL INTERIM PAYMENTS		312333	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01		5.01
	TO .02	NONE	5.02
	PROVIDER .03		5.03
	PROVIDER .50		5.50
	TO .51	NONE	5.51
	PROGRAM .52		5.52
SUBTOTAL	.99		5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER .01 PROVIDER TO .02 PROGRAM	-34356	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		277977	7
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____	
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____	

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

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RHC II  
 COMPONENT NO: 14-3485

WORKSHEET M-1

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

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN								1
2 PHYSICIAN ASSISTANT	33542		33542		33542		33542	2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	33542		33542		33542		33542	10
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS								14
15 MEDICAL SUPPLIES								15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS		34095	34095		34095		34095	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		34095	34095		34095		34095	21
22 TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES	33542	34095	67637		67637		67637	22
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS FACILITY OVERHEAD								28
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS								30
31 TOTAL FACILITY OVERHEAD								31
32 TOTAL FACILITY COSTS	33542	34095	67637		67637		67637	32

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/2000)

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RHC II  
 COMPONENT NO: 14-3485

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1 PHYSICIANS			4200			1
2 PHYSICIAN ASSISTANTS	0.24	677	2100	504		2
3 NURSE PRACTITIONERS			2100			3
4 SUBTOTAL	0.24	677		504	677	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	0.24	677			677	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					67637	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					67637	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD						14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					26536	15
16 TOTAL OVERHEAD					26536	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					26536	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					26536	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					94173	20

RHC II  
 COMPONENT NO: 14-3485

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	94173	1
2	COST OF VACCINES AND THEIR ADMINISTRATION		2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	94173	3
4	TOTAL VISITS	677	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	677	6
7	ADJUSTED COST PER VISIT	139.10	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT			8
9	RATE FOR PROGRAM COVERED VISITS	139.10	139.10	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	50	88	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	6955	12241	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST			19196 16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE			2264 17
18	NET PROGRAM COST EXCLUDING VACCINES			16932 18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			13546 19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			20
21	TOTAL REIMBURSABLE PROGRAM COST			13546 21
22	REIMBURSABLE BAD DEBTS			22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT			13546 24
25	INTERIM PAYMENTS			6164 25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM			7382 26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			27

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	33542	33542	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME			2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST			3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE			4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE			5
6 TOTAL DIRECT COST OF THE FACILITY	67637	67637	6
7 TOTAL OVERHEAD	26536	26536	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST			8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE			9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION			10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS			11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION			12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES			13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			16

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
 02/11/2010 11:52

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

RHC II  
 COMPONENT NO: 14-3485

WORKSHEET M-5

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		6164	1
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	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	PROGRAM .01		3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	TO .02		3.02
REVISION OF THE INTERIM RATE FOR THE COST	PROVIDER .03	NONE	3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	TO .04		3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .05		3.05
	PROVIDER .50		3.50
	TO .51		3.51
	PROGRAM .52	NONE	3.52
	TO .53		3.53
	PROGRAM .54		3.54
SUBTOTAL	.99		3.99
4 TOTAL INTERIM PAYMENTS		6164	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01		5.01
	TO .02	NONE	5.02
	PROVIDER .03		5.03
	PROVIDER .50		5.50
	TO .51	NONE	5.51
	PROGRAM .52		5.52
SUBTOTAL	.99		5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	7382	6.01
	PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY	PROGRAM	13546	7
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____	
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____	

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
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RHC III  
 COMPONENT NO: 14-3496

WORKSHEET M-1

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

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN								1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	242813	59517	302330		302330		302330	9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	242813	59517	302330		302330		302330	10
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS								14
15 MEDICAL SUPPLIES								15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)								21
22 TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES	242813	59517	302330		302330		302330	22
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS								30
31 TOTAL FACILITY OVERHEAD								31
32 TOTAL FACILITY COSTS	242813	59517	302330		302330		302330	32

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2009.08  
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RHC III  
 COMPONENT NO: 14-3496

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1 PHYSICIANS	0.89	5137	4200	3738		1
2 PHYSICIAN ASSISTANTS			2100			2
3 NURSE PRACTITIONERS			2100			3
4 SUBTOTAL	0.89	5137		3738	5137	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	0.89	5137			5137	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					302330	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					302330	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD						14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					131851	15
16 TOTAL OVERHEAD					131851	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					131851	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					131851	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					434181	20

RHC III  
 COMPONENT NO: 14-3496

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	434181	1
2	COST OF VACCINES AND THEIR ADMINISTRATION		2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	434181	3
4	TOTAL VISITS	5137	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	5137	6
7	ADJUSTED COST PER VISIT	84.52	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT			8
9	RATE FOR PROGRAM COVERED VISITS	84.52	84.52	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	192	889	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	16228	75138	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST			91366 16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE			12337 17
18	NET PROGRAM COST EXCLUDING VACCINES			79029 18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			63223 19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			20
21	TOTAL REIMBURSABLE PROGRAM COST			63223 21
22	REIMBURSABLE BAD DEBTS			22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT			63223 24
25	INTERIM PAYMENTS			41293 25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM			21930 26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			27

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

RHC III  
 COMPONENT NO: 14-3496

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	302330	302330	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME			2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST			3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE			4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE			5
6 TOTAL DIRECT COST OF THE FACILITY	302330	302330	6
7 TOTAL OVERHEAD	131851	131851	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST			8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE			9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION			10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS			11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION			12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES			13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			16

PROVIDER NO. 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2008 TO 09/30/2009

KPMG LLP COMPU-MAX MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.08  
 02/11/2010 11:52

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

RHC III  
 COMPONENT NO: 14-3496

WORKSHEET M-5

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		41293	1
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	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	PROGRAM .01		3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	TO .02		3.02
REVISION OF THE INTERIM RATE FOR THE COST	PROVIDER .03	NONE	3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	TO .04		3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .05		3.05
	PROVIDER .50		3.50
	TO .51		3.51
	PROGRAM .52	NONE	3.52
	TO .53		3.53
	PROGRAM .54		3.54
SUBTOTAL	.99		3.99
4 TOTAL INTERIM PAYMENTS		41293	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01		5.01
	TO .02	NONE	5.02
	PROVIDER .03		5.03
	PROVIDER .50		5.50
	TO .51	NONE	5.51
	PROGRAM .52		5.52
SUBTOTAL	.99		5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	21930	6.01
	PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		63223	7
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____	
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____	

\*\*\*\*\* REPORT 97 \*\*\*\*\* UTILIZATION STATISTICS \*\*\*\*\*

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	61.56		5.14				66.70 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
37 OPERATING ROOM	0.67	45.91					46.58 37
41 RADIOLOGY-DIAGNOSTIC	3.36	25.70					29.06 41
44 LABORATORY	8.38	29.12					37.50 44
49 RESPIRATORY THERAPY	15.24	31.64					46.88 49
50 PHYSICAL THERAPY	3.73	18.55					22.28 50
55 MEDICAL SUPPLIES CHARGED TO PAT	13.97	33.18					47.15 55
56 DRUGS CHARGED TO PATIENTS	18.12	13.50					31.62 56
60 CLINIC		55.95					55.95 60
61 EMERGENCY	0.11	26.29					26.40 61
62 OBSERVATION BEDS (NON-DISTINCT		36.34					36.34 62
101 TOTAL CHARGES	4.63	20.50					25.13 101

\*\*\*\*\* REPORT 97 \*\*\*\*\* UTILIZATION STATISTICS \*\*\*\*\*

SNF / NF

COST CENTERS	SNF		NF		NF		TOTAL THIRD PARTY UTIL
	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
34 SKILLED NURSING FACILITY	2.26						2.26 34
UTILIZATION PERCENTAGES BASED ON CHARGES							
41 RADIOLOGY-DIAGNOSTIC	0.12						0.12 41
44 LABORATORY	0.21						0.21 44
49 RESPIRATORY THERAPY	0.29						0.29 49
50 PHYSICAL THERAPY	7.84						7.84 50
55 MEDICAL SUPPLIES CHARGED TO PAT	0.61						0.61 55
56 DRUGS CHARGED TO PATIENTS	2.40						2.40 56
101 TOTAL CHARGES	0.69						0.69 101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	640469	3.93	-640469	-8.87			3
4 NEW CAP REL COSTS-MVBLE EQUIP	530391	3.25	-530391	-7.34			4
5 EMPLOYEE BENEFITS	748579	4.59	-748579	-10.37			5
6 ADMINISTRATIVE & GENERAL	3254634	19.96	-3254634	-45.07			6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	644875	3.96	-644875	-8.93			8
9 LAUNDRY & LINEN SERVICE	97903	.60	-97903	-1.36			9
10 HOUSEKEEPING	312579	1.92	-312579	-4.33			10
11 DIETARY	603466	3.70	-603466	-8.36			11
12 CAFETERIA							12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION	12598	.08	-12598	-.17			14
15 CENTRAL SERVICES & SUPPLY							15
16 PHARMACY							16
17 MEDICAL RECORDS & LIBRARY	322306	1.98	-322306	-4.46			17
18 SOCIAL SERVICE	54009	.33	-54009	-.75			18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES A							22
23 I&R SERVICES-OTHER PRGM COSTS A							23
24 PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS							
25 ADULTS & PEDIATRICS	787216	4.83	785034	10.87	1572250	9.64	25
34 SKILLED NURSING FACILITY	1503911	9.23	1974781	27.34	3478692	21.34	34
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	252257	1.55	232790	3.22	485047	2.98	37
40 ANESTHESIOLOGY	34597	.21	16415	.23	51012	.31	40
41 RADIOLOGY-DIAGNOSTIC	781954	4.80	565107	7.83	1347061	8.26	41
44 LABORATORY	655764	4.02	384617	5.33	1040381	6.38	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	54899	.34	93194	1.29	148093	.91	49
50 PHYSICAL THERAPY	458376	2.81	216383	3.00	674759	4.14	50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
55 MEDICAL SUPPLIES CHARGED TO PAT	745926	4.58	275394	3.81	1021320	6.27	55
56 DRUGS CHARGED TO PATIENTS	624161	3.83	223288	3.09	847449	5.20	56
60 CLINIC	76807	.47	63438	.88	140245	.86	60
61 EMERGENCY	1175816	7.21	693557	9.60	1869373	11.47	61
62 OBSERVATION BEDS (NON-DISTINCT)							62
63.50 RHC	942189	5.78	654696	9.07	1596885	9.80	63.50
63.51 RHC II	67637	.41	26536	.37	94173	.58	63.51
63.52 RHC III	302330	1.85	131851	1.83	434181	2.66	63.52
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES	402350	2.47	174215	2.41	576565	3.54	65

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
OUTPATIENT SERVICE COST CENTERS							
69.10	CMHC						69.10
69.20	OUTPATIENT PHYSICAL THERAPY						69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY						69.30
69.40	OUTPATIENT SPEECH PATHOLOGY						69.40
71	HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION						85.01
85.02	INTESTINAL ACQUISITION						85.02
85.03	ISLET CELL ACQUISITION						85.03
NONREIMBURSABLE COST CENTERS							
96	GIFT, FLOWER, COFFEE SHOP & CAN			45773	.63	45773	.28
99.01	ASSISTED LIVING	213700	1.31	664740	9.20	878440	5.39
100	FOUNDATION						100
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL	16301699	100.00	0	.00	16301699	100.00

\*\*\*\* THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	1956858
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	8022399
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.244