

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 03-29-2012 TIME: 20:24
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 USE ONLY 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED 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 10/01/2010 AND ENDING 09/30/2011, AND 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 IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		251,916	-252,116		74,206	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		40,564				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			88,730			10
10.01 HEALTH CLINIC - RHC II			3,487			10.01
10.02 HEALTH CLINIC - RHC III			-5,535			10.02
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		292,480	-165,434		74,206	200

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 673 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: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 701 EAST ORANGE
 2 CITY: HOOPSETON

STATE: IL

P.O.BOX:
 ZIP CODE: 60942

COUNTY: VERMILLION

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	HOOPESTON COMMUNITY MEMORIAL	14-1316	16974	1	11/01/2001	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	HOOPESTON CMH SWING BED	14-Z316	16974		11/01/2001	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	HOOPESTON CMH SKILLED CARE	14-5470	16974		11/01/2001	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	HOOPESTON MEDICAL CENTER RHC	14-3448	16974		04/01/1998	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	CISSNA PARK	14-3485	16974		10/11/2006	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	ROSSVILLE CLINIC	14-3496	16974		10/01/2008	N	O	N	15.02
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 10/01/2010 TO: 09/30/2011									20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.									1 N	2 N
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.										N 23

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.						24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.						25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.						26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.						27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.						36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.						38

	V 1	XVIII 2	XIX 3	
45	PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL			
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?			
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.			
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.			
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.			

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				64
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
1	2	3	4	5	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			N 75
76	IF LINE 75 YES: COLUMN 1: DID 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. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 106
107	COLUMN 1: 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 IN COLUMN 1. 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, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N N 107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- SICAL ATIONAL SPEECH RATORY	Y Y Y N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.		2,000,000 4,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N		140
-----	--	---	--	-----

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B.

SEE 42 CFR §413.13)

	PART A	PART B
155 HOSPITAL	N	N 155
156 SUBPROVIDER - IPF	N	N 156
157 SUBPROVIDER - IRF	N	N 157
158 SUBPROVIDER - (OTHER)	N	N 158
159 SNF	N	N 159
160 HHA	N	N 160
161 CMHC	N	N 161

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		165		
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE	
PROVIDER ORGANIZATION AND OPERATION				
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N	2	1
		Y/N	DATE	V/I
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N	2	3
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3

		Y/N	TYPE	DATE
FINANCIAL DATA AND REPORTS				
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	N	2	3
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5

		Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES				
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N	7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N	8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N	9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N	11	
				Y/N
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		N	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			14

BED COMPLEMENT				
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	03/21/2012	Y	03/21/2012
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. N 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. Y 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. Y 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. Y 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. Y 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. N 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. N 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 35

HOME OFFICE COSTS

- 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? Y/N 1 DATE 2 36
- 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. N 37
- 38 IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. N 38
- 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. 39
- 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 40

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	9,113,182	-228,112		477,034.00		1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44	1,285,413	-2,164		89,808.00		9
10		426,221			46,931.00		10
11		787,710			12,183.00		11
12							12
13							13
14							14
15							15
16							16
17		1,546,366					17
18							18
19		332,289					19
20							20
21							21
22							22
23							23
24							24
25							25
26		90,754			3,404.00		26
27		1,078,256	198,786		64,266.00		27
28							28
29							29
30		178,734			14,769.00		30
31							31
32		238,475			26,361.00		32
33							33
34		373,673			36,793.00		34
35							35
36							36
37							37
38		100,800	-100,800				38
39							39
40							40
41		220,458	53,987		14,889.00		41
42		51,850			3,033.00		42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	9,113,182	-228,112	8,885,070	477,034.00	18.63	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	1,711,634	-2,164	1,709,470	136,739.00	12.50	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7,401,548	-225,948	7,175,600	340,295.00	21.09	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	787,710		787,710	12,183.00	64.66	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	1,546,366		1,546,366		21.55	5
6	TOTAL (SUM OF LINES 3 THRU 5)	9,735,624	-225,948	9,509,676	352,478.00	26.98	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	2,333,000	151,973	2,484,973	163,515.00	15.20	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	60,471	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST		3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	960,220	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)		11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	103,633	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	635,326	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	119,005	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT		23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	1,878,655	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II		14.01
14.02	HOSPITAL-BASED HEALTH CLINIC - RHC III		14.02
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	11/01/2001	2

	GROUP	SNF	SWING BED	TOTAL
	1	DAYS	SNF DAYS	(COLS.
		2	3	2 + 3)
				4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB			16
17	RVA	3		3
18	RHC	7		7
19	RHB	34		34
20	RHA	91		91
21	RMC	53		53
22	RMB	31		31
23	RMA	243		243
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1	21		21
29	HE2			29
30	HE1	14		14
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1	14		14
35	HB2			35
36	HB1	19		19
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1	3		3
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1	14		14
49	CC2	14		14
50	CC1	23		23
51	CB2			51
52	CB1			52
53	CA2			53
54	CA1	9		9
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1			66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1		26		26 70
71	PD2				71
72	PD1		34		34 72
73	PC2				73
74	PC1		55		55 74
75	PB2				75
76	PB1		11		11 76
77	PA2				77
78	PA1		7		7 78
199	AAA				199
200	TOTAL		726		726 200

		CBSA AT	CBSA	
		BEGINNING	ON/AFTER	
		OF COST	REPORTING	
		REPORTING	PERIOD (IF	
		PERIOD	APPLICABLE)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).	00014	00014	201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 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. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	3,977,336			207

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

RHC I
 COMPONENT NO: 14-3448

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 801 EAST ORANGE STREET										1
2	CITY: HOOPESTON	STATE: IL	ZIP CODE: 60452	COUNTY: VERMILION							2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN										3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)			4
5	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)			5
6	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER			9

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC?
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.

		1	2	
		N		10

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			
11	CLINIC	0		1	2	3	4	5	6	7	8	9	10	11	12	13	14	11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	1	2	
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	N		12
14	PROVIDER NAME:	N		13

14 PROVIDER NAME: CCN NUMBER: 14

15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)	Y/N	V	XVIII	XIX	
		N				15

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

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

RHC II
COMPONENT NO: 14-3485

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 141 W GARFIELD AVE. 1
2 CITY: CISSNA PARK STATE: IL ZIP CODE: 60924 COUNTY: IRIQUOIS 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	DATE	
	1	2	
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)			4
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)			5
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)			6
7 APPALACHIAN REGIONAL COMMISSION			7
8 LOOK-ALIKES			8
9 OTHER			9

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 1 2
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

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	
11 CLINIC			0830	1300	0830	1300	0830	1300	0830	1300	0830	1300			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2
N 12

13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 13
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO Y/N V XVIII XIX 15
IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

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

RHC III
COMPONENT NO: 14-3496

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: ROSSVILLE CLINIC 1
2 CITY: STATE: ZIP CODE: COUNTY: 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

GRANT AWARD DATE
1 2
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 4
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 5
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) 6
7 APPALACHIAN REGIONAL COMMISSION 7
8 LOOK-ALIKES 8
9 OTHER 9

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 1 2
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

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	
11 CLINIC															11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2
N 12
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 13
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE

NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.
14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO Y/N V XVIII XIX 15
IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED N
BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.401314	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				2,270,322	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				7,885,629	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,164,613	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				894,291	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				894,291	19
			UNINSURED PATIENTS	INSURED PATIENTS		TOTAL
			1	2		3
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY		1,707,928		1,707,928	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)		685,415		685,415	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE					22
23	COST OF CHARITY CARE		685,415		685,415	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				1,391,977	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				353,337	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				1,038,640	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				416,821	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				1,102,236	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				1,996,527	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100				499,919	1
2	00200		853,733	853,733	2,247	2
3	00300					3
4	00400	90,754	49,810	140,564	1,203,821	4
5	00500	1,078,256	4,121,652	5,199,908	-1,458,560	5
6	00600					6
7	00700	178,734	449,680	628,414	30,973	7
8	00800		113,266	113,266		8
9	00900	238,475	57,781	296,256		9
10	01000	373,673	318,254	691,927		10
11	01100					11
12	01200					12
13	01300	100,800	7,450	108,250	-106,623	13
14	01400					14
15	01500					15
16	01600	220,458	94,069	314,527	53,987	16
17	01700	51,850	6,644	58,494		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	716,176	113,687	829,863	2,445	30
44	04400	1,285,413	266,715	1,552,128	31,333	44
ANCILLARY SERVICE COST CENTERS						
50	05000	329,152	1,526,712	1,855,864	-1,093,115	50
53	05300	228,112	45,625	273,737		53
54	05400	487,090	1,007,947	1,495,037		54
60	06000	319,789	523,249	843,038		60
62.30	06250					62.30
65	06500	7,424	47,977	55,401		65
66	06600	59,035	352,706	411,741		66
67	06700					67
68	06800					68
71	07100		200,802	200,802	88,446	71
72	07200				1,004,669	72
73	07300	6,388	589,495	595,883		73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	1,641,066	434,693	2,075,759	-190,675	88
88.01	08801	190,319	38,650	228,969		88.01
88.02	08802	218,129	75,337	293,466	-21,206	88.02
90	09000	86,309	194,196	280,505	-1,876	90
91	09100	779,559	1,289,256	2,068,815	-95,208	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	293,629	134,579	428,208		95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
118		8,980,590	12,913,965	21,894,555	-49,423	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
193.01	19301	132,592	34,631	167,223	49,423	193.01
194	07950					194
200		9,113,182	12,948,596	22,061,778		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100 CAP REL COSTS-BLDG & FIXT	499,919	-45,345	454,574	1
2	00200 CAP REL COSTS-MVBLE EQUIP	855,980	304,106	1,160,086	2
3	00300 OTHER CAPITAL RELATED COSTS				3
4	00400 EMPLOYEE BENEFITS	1,344,385	-10,461	1,333,924	4
5	00500 ADMINISTRATIVE & GENERAL	3,741,348	-65,113	3,676,235	5
6	00600 MAINTENANCE & REPAIRS				6
7	00700 OPERATION OF PLANT	659,387		659,387	7
8	00800 LAUNDRY & LINEN SERVICE	113,266		113,266	8
9	00900 HOUSEKEEPING	296,256		296,256	9
10	01000 DIETARY	691,927	-52,578	639,349	10
11	01100 CAFETERIA				11
12	01200 MAINTENANCE OF PERSONNEL				12
13	01300 NURSING ADMINISTRATION	1,627		1,627	13
14	01400 CENTRAL SERVICES & SUPPLY				14
15	01500 PHARMACY				15
16	01600 MEDICAL RECORDS & LIBRARY	368,514	-3,521	364,993	16
17	01700 SOCIAL SERVICE	58,494		58,494	17
19	01900 NONPHYSICIAN ANESTHETISTS				19
20	02000 NURSING SCHOOL				20
21	02100 I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000 ADULTS & PEDIATRICS	832,308		832,308	30
44	04400 SKILLED NURSING FACILITY	1,583,461		1,583,461	44
ANCILLARY SERVICE COST CENTERS					
50	05000 OPERATING ROOM	762,749		762,749	50
53	05300 ANESTHESIOLOGY	273,737	-232,112	41,625	53
54	05400 RADIOLOGY-DIAGNOSTIC	1,495,037		1,495,037	54
60	06000 LABORATORY	843,038		843,038	60
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500 RESPIRATORY THERAPY	55,401		55,401	65
66	06600 PHYSICAL THERAPY	411,741		411,741	66
67	06700 OCCUPATIONAL THERAPY				67
68	06800 SPEECH PATHOLOGY				68
71	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	289,248		289,248	71
72	07200 IMPL. DEV. CHARGED TO PATIENT	1,004,669		1,004,669	72
73	07300 DRUGS CHARGED TO PATIENTS	595,883		595,883	73
76.97	07697 CARDIAC REHABILITATION				76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
88	08800 RURAL HEALTH CLINIC (RHC)	1,885,084	-10,104	1,874,980	88
88.01	08801 RHC II	228,969		228,969	88.01
88.02	08802 RHC III	272,260		272,260	88.02
90	09000 CLINIC	278,629		278,629	90
91	09100 EMERGENCY	1,973,607	-737,015	1,236,592	91
92	09200 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS					
95	09500 AMBULANCE SERVICES	428,208		428,208	95
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	21,845,132	-852,143	20,992,989	118
NONREIMBURSABLE COST CENTERS					
190	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
193.01	19301 ASSISTED LIVING	216,646		216,646	193.01
194	07950 FOUNDATION				194
200	TOTAL (SUM OF LINES 118-199)	22,061,778	-852,143	21,209,635	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 INTEREST EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1			574,855 1
500 TOTAL RECLASSIFICATIONS						574,855 500
CODE LETTER - A						
1 RENT EXPENSE	B	CAP REL COSTS-MVBLE EQUIP	2			2,247 1
500 TOTAL RECLASSIFICATIONS						2,247 500
CODE LETTER - B						
1 CAPITAL INSURANCE	C	CAP REL COSTS-BLDG & FIXT	1			49,131 1
500 TOTAL RECLASSIFICATIONS						49,131 500
CODE LETTER - C						
1 UTILITY EXPENSE	D	OPERATION OF PLANT	7			30,973 1
2						2
3						3
4						4
500 TOTAL RECLASSIFICATIONS						30,973 500
CODE LETTER - D						
1 ACTIVITIES THERAPY	E	ADULTS & PEDIATRICS	30		2,164	281 1
500 TOTAL RECLASSIFICATIONS					2,164	281 500
CODE LETTER - E						
1 INSURANCE EXPENSE	F	ADMINISTRATIVE & GENERAL	5			189,921 1
2						2
500 TOTAL RECLASSIFICATIONS						189,921 500
CODE LETTER - F						
1 CRNA SALARIES	G	ANESTHESIOLOGY	53			228,112 1
500 TOTAL RECLASSIFICATIONS						228,112 500
CODE LETTER - G						
1 DEPRECIATION EXPENSE	H	SKILLED NURSING FACILITY	44			45,047 1
2		RURAL HEALTH CLINIC (RHC)	88			29,597 2
3		ASSISTED LIVING	193.01			49,423 3
500 TOTAL RECLASSIFICATIONS						124,067 500
CODE LETTER - H						
1 ADMINISTRATIVE SALARIES	I	ADMINISTRATIVE & GENERAL	5		251,328	5,823 1
2		MEDICAL RECORDS & LIBRARY	16		53,987	2
3						3
500 TOTAL RECLASSIFICATIONS					305,315	5,823 500
CODE LETTER - I						
1 RHC SPECIALTY PHYSICIAN	J	RURAL HEALTH CLINIC (RHC)	88		52,542	18,258 1
500 TOTAL RECLASSIFICATIONS					52,542	18,258 500
CODE LETTER - J						
1		EMPLOYEE BENEFITS	4			1,203,821 1
500 TOTAL RECLASSIFICATIONS						1,203,821 500
CODE LETTER -						
1 SURGERY SUPPLIES	L	IMPL. DEV. CHARGED TO PATIENT	72			1,004,669 1
2		MEDICAL SUPPLIES CHRGD TO PA	71			88,446 2
500 TOTAL RECLASSIFICATIONS						1,093,115 500
CODE LETTER - L						
GRAND TOTAL (INCREASES)					360,021	3,520,604

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7	
			LINE #	SALARY		REF.	
1	1	6	7	8	9	10	
1 INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	5		574,855	11	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					574,855		500
1 RENT EXPENSE	B	SKILLED NURSING FACILITY	44		2,247	11	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					2,247		500
1 CAPITAL INSURANCE	C	ADMINISTRATIVE & GENERAL	5		49,131	11	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					49,131		500
1 UTILITY EXPENSE	D	ADMINISTRATIVE & GENERAL	5		7,025		1
2		SKILLED NURSING FACILITY	44		9,022		2
3		CLINIC	90		1,876		3
4		RURAL HEALTH CLINIC (RHC)	88		13,050		4
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					30,973		500
1 ACTIVITIES THERAPY	E	SKILLED NURSING FACILITY	44	2,164	281		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E				2,164	281		500
1 INSURANCE EXPENSE	F	EMERGENCY	91		95,208		1
2		RURAL HEALTH CLINIC (RHC)	88		94,713		2
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					189,921		500
1 CRNA SALARIES	G	ANESTHESIOLOGY	53	228,112			1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G				228,112			500
1 DEPRECIATION EXPENSE	H	CAP REL COSTS-BLDG & FIXT	1		124,067	9	1
2							2
3							3
500 TOTAL RECLASSIFICATIONS CODE LETTER - H					124,067		500
1 ADMINISTRATIVE SALARIES	I	NURSING ADMINISTRATION	13	100,800	5,823		1
2		RURAL HEALTH CLINIC (RHC)	88	183,309			2
3		RHC III	88.02	21,206			3
500 TOTAL RECLASSIFICATIONS CODE LETTER - I				305,315	5,823		500
1 RHC SPECIALTY PHYSICIAN	J	ADMINISTRATIVE & GENERAL	5	52,542	18,258		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - J				52,542	18,258		500
1		ADMINISTRATIVE & GENERAL	5		1,203,821		1
500 TOTAL RECLASSIFICATIONS CODE LETTER -					1,203,821		500
1 SURGERY SUPPLIES	L	OPERATING ROOM	50		1,093,115		1
2							2
500 TOTAL RECLASSIFICATIONS CODE LETTER - L					1,093,115		500
GRAND TOTAL (DECREASES)				588,133	3,292,492		

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN 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	391,970					391,970		1
2 LAND IMPROVEMENTS	72,519					72,519		2
3 BUILDINGS AND FIXTURES	10,318,752					10,318,752		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	431,478					431,478		5
6 MOVABLE EQUIPMENT	3,714,531					3,714,531		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	14,929,250					14,929,250		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	14,929,250					14,929,250		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT							1
2 CAP REL COSTS-MVBLE EQUIP	853,733						853,733 2
3 TOTAL (SUM OF LINES 1-2)	853,733						853,733 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	-115,907		570,481				454,574 1
2 CAP REL COSTS-MVBLE EQUIP	1,157,839		2,247				1,160,086 2
3 TOTAL	1,041,932		572,728				1,614,660 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
				COST CENTER 3	LINE NO. 4	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-4,117	CAP REL COSTS-BLDG & FIXT	1	11 1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2 3
3	INVESTMENT INCOME-OTHER (CHAPTER 2)					4
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					5
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					6
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					7
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					8
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)					9
9	PARKING LOT (CHAPTER 21)					10
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-737,015			11
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					12
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				13
13	LAUNDRY AND LINEN SERVICE					14
14	CAPETERIA - EMPLOYEES AND GUESTS	B	-26,905	DIETARY	10	15
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					16
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					17
17	SALE OF DRUGS TO OTHER THAN PATIENTS					18
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3,521	MEDICAL RECORDS & LIBRARY	16	19
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					20
20	VENDING MACHINES					21
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					22
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					23
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	25
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	26
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	27
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	28
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	29
29	PHYSICIANS' ASSISTANT					30
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	31
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	32
32	CAH HIT ADJ FOR DEPRECIATION AND CATERING	B	-25,673	DIETARY	10	33
33						34
34	LOBBYING EXPENSE	A	-6,652	ADMINISTRATIVE & GENERAL	5	35
35	LOSS ON REFUNDING	A	304,106	CAP REL COSTS-MVBLE EQUIP	2	9 36
36	MARKETING SALARIES	A	-36,853	ADMINISTRATIVE & GENERAL	5	37
37	MARKETING EXPENSE	A	-15,330	ADMINISTRATIVE & GENERAL	5	38
38	MARKETING BENEFITS	A	-2,652	ADMINISTRATIVE & GENERAL	5	39
39	MISCELLANEOUS REVENUE	B	-3,626	ADMINISTRATIVE & GENERAL	5	40
40	MISCELLANEOUS REVENUE	B	-8,254	RURAL HEALTH CLINIC (RHC)	88	41
41	CLINIC MEDICAL RECORDS	B	-1,850	RURAL HEALTH CLINIC (RHC)	88	42
42	CRNA SALARIES	A	-228,112	ANESTHESIOLOGY	53	43
43	CRNA BENEFITS	A	-10,461	EMPLOYEE BENEFITS	4	43.01
43.01	CRNA OTHER	A	-4,000	ANESTHESIOLOGY	53	43.02
43.02						44
44	UNNECESSARY BORROWING	A	-49,388	CAP REL COSTS-BLDG & FIXT	1	11 45
45	POB LAPSING SCHEDULE	A	8,160	CAP REL COSTS-BLDG & FIXT	1	9 45.02
45.02						46
46						47
47						48
48						49
49						50
50	TOTAL (SUM OF LINES 1 THRU 49)		-852,143			
	TRANSFER TO WKST A, COL. 6, LINE 200)					

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 (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4)					
	TRANSFER COL. 6, LINE 5 TO					
	WKST A-8, COL. 2, LINE 12.					

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.

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----						
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6						6
7						7
8						8
9						9
10						10

- (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:

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

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	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
LINE NO.	1	2	3	4	5	6	7	8	9
4	91	EMERGENCY	AGGREGATE	1,038,000	737,015	300,985			
200		TOTAL		1,038,000	737,015	300,985			4 200

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

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

WORKSHEET A-8-3
 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		483.00	1,603.00			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					34,404	15
16	ASSISTANTS					85,648	16
17	SUBTOTAL ALLOWANCE AMOUNT					120,052	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					120,052	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					120,052	23

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

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

WORKSHEET A-8-3
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	11,398	24
25 ASSISTANTS	1,202	25
26 SUBTOTAL	12,600	26
27 STANDARD TRAVEL EXPENSE		27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	12,600	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	12,600	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 CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

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

WORKSHEET A-8-3
 PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					120,052	57
58					12,600	58
59						59
60						60
61						61
62						62
63					132,652	63
64					97,728	64
65						65

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

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

WORKSHEET A-8-3
 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		2,105.00	1,856.00			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					149,939	15
16	ASSISTANTS					99,166	16
17	SUBTOTAL ALLOWANCE AMOUNT					249,105	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					249,105	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					249,105	23

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

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

WORKSHEET A-8-3
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	4,987	24
25 ASSISTANTS	6,012	25
26 SUBTOTAL	10,999	26
27 STANDARD TRAVEL EXPENSE		27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	10,999	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	10,999	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 CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

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

WORKSHEET A-8-3
 PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					249,105	57
58					10,999	58
59						59
60						60
61						61
62						62
63					260,104	63
64					210,530	64
65						65

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

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

WORKSHEET A-8-3
PARTS I & II

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] 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						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						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		178.00				9
10	AHSEA		71.23				10
11	STANDARD TRAVEL ALLOWANCE	35.62	35.62				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					12,679	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					12,679	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					12,679	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					71.23	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					55,559	22
23	TOTAL SALARY EQUIVALENCY					55,559	23

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

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

WORKSHEET A-8-3
PARTS III & IV

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

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	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	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 CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

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

WORKSHEET A-8-3
 PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					55,559	57
58						58
59						59
60						60
61						61
62						62
63					55,559	63
64					11,198	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	454,574	454,574				1
2 CAP REL COSTS-MVBLE EQUIP	1,160,086		1,160,086			2
4 EMPLOYEE BENEFITS	1,333,924			1,333,924		4
5 ADMINISTRATIVE & GENERAL 6 MAINTENANCE & REPAIRS	3,676,235	242,473	618,796	193,702	4,731,206	5
7 OPERATION OF PLANT	659,387	25,705	65,599	27,110	777,801	7
8 LAUNDRY & LINEN SERVICE	113,266	7,314	18,666		139,246	8
9 HOUSEKEEPING	296,256	5,841	14,906	36,172	353,175	9
10 DIETARY	639,349	22,819	58,236	56,679	777,083	10
11 CAFETERIA		3,710	9,467		13,177	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,627	6,043	15,421		23,091	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	364,993	7,402	18,890	41,628	432,913	16
17 SOCIAL SERVICE	58,494	2,640	6,737	7,865	75,736	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	832,308	26,441	67,479	108,958	1,035,186	30
44 SKILLED NURSING FACILITY	1,583,461			194,643	1,778,104	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	762,749	13,725	35,027	49,926	861,427	50
53 ANESTHESIOLOGY	41,625				41,625	53
54 RADIOLOGY-DIAGNOSTIC	1,495,037	31,309	79,901	73,882	1,680,129	54
60 LABORATORY	843,038	11,603	29,610	48,506	932,757	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	55,401	4,297	10,967	1,126	71,791	65
66 PHYSICAL THERAPY	411,741	5,867	14,973	8,954	441,535	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	289,248	6,349	16,204		311,801	71
72 IMPL. DEV. CHARGED TO PATIENT	1,004,669				1,004,669	72
73 DRUGS CHARGED TO PATIENTS	595,883	2,201	5,618	969	604,671	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,874,980			229,082	2,104,062	88
88.01 RHC II	228,969			28,868	257,837	88.01
88.02 RHC III	272,260			29,869	302,129	88.02
90 CLINIC	278,629	6,288	16,047	13,091	314,055	90
91 EMERGENCY	1,236,592	14,356	36,638	118,244	1,405,830	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	428,208			44,538	472,746	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	20,992,989	446,383	1,139,182	1,313,812	20,943,782	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		8,191	20,904		29,095	190
193.01 ASSISTED LIVING	216,646			20,112	236,758	193.01
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	21,209,635	454,574	1,160,086	1,333,924	21,209,635	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	4,731,206					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	223,318	1,001,119				7
8 LAUNDRY & LINEN SERVICE	39,980	11,149	190,375			8
9 HOUSEKEEPING	101,402	8,903		463,480		9
10 DIETARY	223,112	34,783		16,221	1,051,199	10
11 CAFETERIA	3,783	5,655		2,637	108,602	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	6,630	9,210		4,295		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	124,296	11,282		5,262		16
17 SOCIAL SERVICE	21,745	4,024		1,876		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	297,217	40,304	64,654	18,796	50,649	30
44 SKILLED NURSING FACILITY	510,520	380,149	82,212	177,287	691,536	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	247,329	20,920		9,756		50
53 ANESTHESIOLOGY	11,951					53
54 RADIOLOGY-DIAGNOSTIC	482,390	47,723		22,256		54
60 LABORATORY	267,809	17,685		8,248		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	20,612	6,550		3,055		65
66 PHYSICAL THERAPY	126,771	8,943	552	4,171		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	89,523	9,678		4,514		71
72 IMPL. DEV. CHARGED TO PATIENT	288,456					72
73 DRUGS CHARGED TO PATIENTS	173,610	3,355		1,565		73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	604,109	129,667		60,472		88
88.01 RHC II	74,029					88.01
88.02 RHC III	86,746					88.02
90 CLINIC	90,170	9,585		4,470		90
91 EMERGENCY	403,635	21,883		10,205		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	135,732					95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	4,654,875	781,448	147,418	355,086	850,787	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,354			5,823		190
193.01 ASSISTED LIVING	67,977	219,671	42,957	102,571	200,412	193.01
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	4,731,206	1,001,119	190,375	463,480	1,051,199	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
	11	13	16	17	24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	133,854					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		43,226				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	7,098		580,851			16
17 SOCIAL SERVICE	1,522			104,903		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	16,455	15,794	115,418	19,725	1,674,198	30
44 SKILLED NURSING FACILITY	42,964	9,351	34,089	85,178	3,791,390	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,132	6,122	38,383		1,190,069	50
53 ANESTHESIOLOGY	999				54,575	53
54 RADIOLOGY-DIAGNOSTIC	8,058		91,261		2,331,817	54
60 LABORATORY	7,496		64,420		1,298,415	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			53,683		155,691	65
66 PHYSICAL THERAPY	5,370		28,184		615,526	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					415,516	71
72 IMPL. DEV. CHARGED TO PATIENT					1,293,125	72
73 DRUGS CHARGED TO PATIENTS	1,695				784,896	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	10,696		41,873		2,950,879	88
88.01 RHC II					331,866	88.01
88.02 RHC III					388,875	88.02
90 CLINIC	3,065				421,345	90
91 EMERGENCY	17,089	11,959	112,198		1,982,799	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			1,342		609,820	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	128,639	43,226	580,851	104,903	20,290,802	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					43,272	190
193.01 ASSISTED LIVING	5,215				875,561	193.01
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	133,854	43,226	580,851	104,903	21,209,635	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS		1,674,198	30
44 SKILLED NURSING FACILITY		3,791,390	44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM		1,190,069	50
53 ANESTHESIOLOGY		54,575	53
54 RADIOLOGY-DIAGNOSTIC		2,331,817	54
60 LABORATORY		1,298,415	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY		155,691	65
66 PHYSICAL THERAPY		615,526	66
67 OCCUPATIONAL THERAPY			67
68 SPEECH PATHOLOGY			68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		415,516	71
72 IMPL. DEV. CHARGED TO PATIENT		1,293,125	72
73 DRUGS CHARGED TO PATIENTS		784,896	73
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC (RHC)		2,950,879	88
88.01 RHC II		331,866	88.01
88.02 RHC III		388,875	88.02
90 CLINIC		421,345	90
91 EMERGENCY		1,982,799	91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
95 AMBULANCE SERVICES		609,820	95
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)		20,290,802	118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		43,272	190
193.01 ASSISTED LIVING		875,561	193.01
194 FOUNDATION			194
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)		21,209,635	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL		242,473	618,796	861,269	861,269	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		25,705	65,599	91,304	40,653	7
8	LAUNDRY & LINEN SERVICE		7,314	18,666	25,980	7,278	8
9	HOUSEKEEPING		5,841	14,906	20,747	18,459	9
10	DIETARY		22,819	58,236	81,055	40,615	10
11	CAFETERIA		3,710	9,467	13,177	689	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		6,043	15,421	21,464	1,207	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		7,402	18,890	26,292	22,627	16
17	SOCIAL SERVICE		2,640	6,737	9,377	3,958	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		26,441	67,479	93,920	54,105	30
44	SKILLED NURSING FACILITY					92,934	44
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		13,725	35,027	48,752	45,023	50
53	ANESTHESIOLOGY					2,176	53
54	RADIOLOGY-DIAGNOSTIC		31,309	79,901	111,210	87,814	54
60	LABORATORY		11,603	29,610	41,213	48,751	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		4,297	10,967	15,264	3,752	65
66	PHYSICAL THERAPY		5,867	14,973	20,840	23,077	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
71	MEDICAL SUPPLIES CHRGD TO PATIENTS		6,349	16,204	22,553	16,297	71
72	IMPL. DEV. CHARGED TO PATIENT					52,510	72
73	DRUGS CHARGED TO PATIENTS		2,201	5,618	7,819	31,604	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)					109,978	88
88.01	RHC II					13,476	88.01
88.02	RHC III					15,791	88.02
90	CLINIC		6,288	16,047	22,335	16,414	90
91	EMERGENCY		14,356	36,638	50,994	73,477	91
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES					24,709	95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (SUM OF LINES 1-117)		446,383	1,139,182	1,585,565	847,374	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		8,191	20,904	29,095	1,521	190
193.01	ASSISTED LIVING					12,374	193.01
194	FOUNDATION						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		454,574	1,160,086	1,614,660	861,269	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	131,957					7
8 LAUNDRY & LINEN SERVICE	1,469	34,727				8
9 HOUSEKEEPING	1,173		40,379			9
10 DIETARY	4,585		1,413	127,668		10
11 CAFETERIA	745		230	13,190	28,031	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,214		374			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,487		458		1,486	16
17 SOCIAL SERVICE	530		163		319	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,312	11,794	1,638	6,151	3,446	30
44 SKILLED NURSING FACILITY	50,110	14,996	15,448	83,987	8,996	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,758		850		1,284	50
53 ANESTHESIOLOGY					209	53
54 RADIOLOGY-DIAGNOSTIC	6,290		1,939		1,688	54
60 LABORATORY	2,331		719		1,570	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	863		266			65
66 PHYSICAL THERAPY	1,179	101	363		1,125	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,276		393			71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	442		136		355	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	17,091		5,268		2,240	88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC	1,263		389		642	90
91 EMERGENCY	2,884		889		3,579	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	103,002	26,891	30,936	103,328	26,939	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			507			190
193.01 ASSISTED LIVING	28,955	7,836	8,936	24,340	1,092	193.01
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	131,957	34,727	40,379	127,668	28,031	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	24,259				13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY		52,350			16
17 SOCIAL SERVICE			14,347		17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	8,863	10,403	2,698	198,330	30
44 SKILLED NURSING FACILITY	5,248	3,072	11,649	286,440	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	3,436	3,459		105,562	50
53 ANESTHESIOLOGY				2,385	53
54 RADIOLOGY-DIAGNOSTIC		8,225		217,166	54
60 LABORATORY		5,806		100,390	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		4,838		24,983	65
66 PHYSICAL THERAPY		2,540		49,225	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				40,519	71
72 IMPL. DEV. CHARGED TO PATIENT				52,510	72
73 DRUGS CHARGED TO PATIENTS				40,356	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		3,774		138,351	88
88.01 RHC II				13,476	88.01
88.02 RHC III				15,791	88.02
90 CLINIC				41,043	90
91 EMERGENCY	6,712	10,112		148,647	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		121		24,830	95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	24,259	52,350	14,347	1,500,004	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				31,123	190
193.01 ASSISTED LIVING				83,533	193.01
194 FOUNDATION					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	24,259	52,350	14,347	1,614,660	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	198,330	30
44	SKILLED NURSING FACILITY	286,440	44
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	105,562	50
53	ANESTHESIOLOGY	2,385	53
54	RADIOLOGY-DIAGNOSTIC	217,166	54
60	LABORATORY	100,390	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	24,983	65
66	PHYSICAL THERAPY	49,225	66
67	OCCUPATIONAL THERAPY		67
68	SPEECH PATHOLOGY		68
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	40,519	71
72	IMPL. DEV. CHARGED TO PATIENT	52,510	72
73	DRUGS CHARGED TO PATIENTS	40,356	73
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
88	RURAL HEALTH CLINIC (RHC)	138,351	88
88.01	RHC II	13,476	88.01
88.02	RHC III	15,791	88.02
90	CLINIC	41,043	90
91	EMERGENCY	148,647	91
92	OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS			
95	AMBULANCE SERVICES	24,830	95
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (SUM OF LINES 1-117)	1,500,004	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,123	190
193.01	ASSISTED LIVING	83,533	193.01
194	FOUNDATION		194
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	1,614,660	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP	CAP	EMPLOYEE	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT SQUARE FEET	BENEFITS GROSS SALARIES			
	1	2	4			
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	51,833					1
2 CAP REL COSTS-MVBLE EQUIP		51,833				2
4 EMPLOYEE BENEFITS			8,794,316			4
5 ADMINISTRATIVE & GENERAL	27,648	27,648	1,277,042	-4,731,206	16,478,429	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,931	2,931	178,734		777,801	7
8 LAUNDRY & LINEN SERVICE	834	834			139,246	8
9 HOUSEKEEPING	666	666	238,475		353,175	9
10 DIETARY	2,602	2,602	373,673		777,083	10
11 CAFETERIA	423	423			13,177	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	689	689			23,091	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	844	844	274,445		432,913	16
17 SOCIAL SERVICE	301	301	51,850		75,736	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,015	3,015	718,340		1,035,186	30
44 SKILLED NURSING FACILITY			1,283,249		1,778,104	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,565	1,565	329,152		861,427	50
53 ANESTHESIOLOGY					41,625	53
54 RADIOLOGY-DIAGNOSTIC	3,570	3,570	487,090		1,680,129	54
60 LABORATORY	1,323	1,323	319,789		932,757	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	490	490	7,424		71,791	65
66 PHYSICAL THERAPY	669	669	59,035		441,535	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	724	724			311,801	71
72 IMPL. DEV. CHARGED TO PATIENT					1,004,669	72
73 DRUGS CHARGED TO PATIENTS	251	251	6,388		604,671	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			1,510,299		2,104,062	88
88.01 RHC II			190,319		257,837	88.01
88.02 RHC III			196,923		302,129	88.02
90 CLINIC	717	717	86,309		314,055	90
91 EMERGENCY	1,637	1,637	779,559		1,405,830	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			293,629		472,746	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	50,899	50,899	8,661,724	-4,731,206	16,212,576	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	934	934			29,095	190
193.01 ASSISTED LIVING			132,592		236,758	193.01
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	454,574	1,160,086	1,333,924		4,731,206	202
203 UNIT COST MULT-WS B PT I	8.769973	22.381224	0.151680		0.287115	203
204 COST TO BE ALLOC PER B PT II					861,269	204
205 UNIT COST MULT-WS B PT II					0.052266	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA
	SQUARE FEET 7	POUNDS OF LAUNDRY 8	SQUARE FEET 9	MEALS SERVED 10	MEALS SERVED 11
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	74,891				7
8 LAUNDRY & LINEN SERVICE	834	243,525			8
9 HOUSEKEEPING	666		74,345		9
10 DIETARY	2,602		2,602	165,517	10
11 CAFETERIA	423		423	17,100	278,756
12 MAINTENANCE OF PERSONNEL					11
13 NURSING ADMINISTRATION	689		689		12
14 CENTRAL SERVICES & SUPPLY					13
15 PHARMACY					14
16 MEDICAL RECORDS & LIBRARY	844		844		15
17 SOCIAL SERVICE	301		301		14,781
19 NONPHYSICIAN ANESTHETISTS					3,170
20 NURSING SCHOOL					17
21 I&R SRVCES-SALARY & FRINGES APPRVD					19
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					20
23 PARAMED ED PRGM-(SPECIFY)					21
INPATIENT ROUTINE SERV COST CENTERS					22
30 ADULTS & PEDIATRICS	3,015	82,705	3,015	7,975	34,269
44 SKILLED NURSING FACILITY	28,438	105,164	28,438	108,886	89,474
ANCILLARY SERVICE COST CENTERS					44
50 OPERATING ROOM	1,565		1,565		12,771
53 ANESTHESIOLOGY					2,080
54 RADIOLOGY-DIAGNOSTIC	3,570		3,570		16,782
60 LABORATORY	1,323		1,323		15,611
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	490		490		65
66 PHYSICAL THERAPY	669	706	669		11,183
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	724		724		71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS	251		251		3,529
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	9,700		9,700		22,275
88.01 RHC II					88
88.02 RHC III					88.01
90 CLINIC	717		717		6,382
91 EMERGENCY	1,637		1,637		35,588
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	58,458	188,575	56,958	133,961	267,895
NONREIMBURSABLE COST CENTERS					118
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			934		190
193.01 ASSISTED LIVING FOUNDATION	16,433	54,950	16,453	31,556	10,861
194 FOUNDATION					193.01
200 CROSS FOOT ADJUSTMENTS					194
201 NEGATIVE COST CENTER					200
202 COST TO BE ALLOC PER B PT I	1,001,119	190,375	463,480	1,051,199	133,854
203 UNIT COST MULT-WS B PT I	13,367681	0.781747	6.234178	6.351003	0.480183
204 COST TO BE ALLOC PER B PT II	131,957	34,727	40,379	127,668	28,031
205 UNIT COST MULT-WS B PT II	1.761987	0.142601	0.543130	0.771329	0.100557

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME SPENT	
	13	16	17	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION	62,891			13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY		10,820		16
17 SOCIAL SERVICE			117	17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	22,979	2,150	22	30
44 SKILLED NURSING FACILITY	13,605	635	95	44
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	8,907	715		50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC		1,700		54
60 LABORATORY		1,200		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY		1,000		65
66 PHYSICAL THERAPY		525		66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				71
72 IMPL. DEV. CHARGED TO PATIENT				72
73 DRUGS CHARGED TO PATIENTS				73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)		780		88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC				90
91 EMERGENCY	17,400	2,090		91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES		25		95
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	62,891	10,820	117	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
193.01 ASSISTED LIVING				193.01
194 FOUNDATION				194
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	43,226	580,851	104,903	202
203 UNIT COST MULT-WS B PT I	0.687316	53.683087	896.606838	203
204 COST TO BE ALLOC PER B PT II	24,259	52,350	14,347	204
205 UNIT COST MULT-WS B PT II	0.385731	4.838262	122.623932	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,674,198		1,674,198		1,674,198	30
44 SKILLED NURSING FACILITY	3,791,390		3,791,390		3,791,390	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,190,069		1,190,069		1,190,069	50
53 ANESTHESIOLOGY	54,575		54,575		54,575	53
54 RADIOLOGY-DIAGNOSTIC	2,331,817		2,331,817		2,331,817	54
60 LABORATORY	1,298,415		1,298,415		1,298,415	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	155,691		155,691		155,691	65
66 PHYSICAL THERAPY	615,526		615,526		615,526	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGED TO	415,516		415,516		415,516	71
72 IMPL. DEV. CHARGED TO PATIE	1,293,125		1,293,125		1,293,125	72
73 DRUGS CHARGED TO PATIENTS	784,896		784,896		784,896	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,950,879		2,950,879		2,950,879	88
88.01 RHC II	331,866		331,866		331,866	88.01
88.02 RHC III	388,875		388,875		388,875	88.02
90 CLINIC	421,345		421,345		421,345	90
91 EMERGENCY	1,982,799		1,982,799		1,982,799	91
92 OBSERVATION BEDS	117,905		117,905		117,905	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	609,820		609,820		609,820	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	20,408,707		20,408,707		20,408,707	200
201 LESS OBSERVATION BEDS	117,905		117,905		117,905	201
202 TOTAL (SEE INSTRUCTIONS)	20,290,802		20,290,802		20,290,802	202

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 (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,714,110		2,714,110			30
44 SKILLED NURSING FACILITY	3,977,366		3,977,366			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	353,904	4,563,414	4,917,318	0.242016	0.242016	0.242016 50
53 ANESTHESIOLOGY	247,496	1,745,180	1,992,676	0.027388	0.027388	0.027388 53
54 RADIOLOGY-DIAGNOSTIC	511,261	9,376,467	9,887,728	0.235829	0.235829	0.235829 54
60 LABORATORY	747,181	5,982,758	6,729,939	0.192931	0.192931	0.192931 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	357,415	1,163,769	1,521,184	0.102349	0.102349	0.102349 65
66 PHYSICAL THERAPY	356,562	1,400,742	1,757,304	0.350267	0.350267	0.350267 66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGD TO	666,298	1,193,026	1,859,324	0.223477	0.223477	0.223477 71
72 IMPL. DEV. CHARGED TO PATIE	1,431,658	190,548	1,622,206	0.797140	0.797140	0.797140 72
73 DRUGS CHARGED TO PATIENTS	833,616	1,012,359	1,845,975	0.425193	0.425193	0.425193 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		2,477,307	2,477,307			88
88.01 RHC II		266,145	266,145			88.01
88.02 RHC III		539,800	539,800			88.02
90 CLINIC		229,917	229,917	1.832596	1.832596	1.832596 90
91 EMERGENCY	188,903	6,670,253	6,859,156	0.289073	0.289073	0.289073 91
92 OBSERVATION BEDS		374,495	374,495	0.314837	0.314837	0.314837 92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		1,282,742	1,282,742	0.475403	0.475403	0.475403 95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	12,385,770	38,468,922	50,854,692			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	12,385,770	38,468,922	50,854,692			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB.	COST REIMB.	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.242016		1,872,137			453,087	50
53 ANESTHESIOLOGY	0.027388						53
54 RADIOLOGY-DIAGNOSTIC	0.235829		2,450,481			577,894	54
60 LABORATORY	0.192931		2,126,964			410,357	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.102349		277,907			28,444	65
66 PHYSICAL THERAPY	0.350267		300,303			105,186	66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.223477		386,946			86,474	71
72 IMPL. DEV. CHARGED TO PATIENT	0.797140		24,952			19,890	72
73 DRUGS CHARGED TO PATIENTS	0.425193		284,458	1,778		120,950	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
88.02 RHC III							88.02
90 CLINIC	1.832596		187,945			344,427	90
91 EMERGENCY	0.289073		1,662,735			480,652	91
92 OBSERVATION BEDS	0.314837		173,208			54,532	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.475403						95
200 SUBTOTAL (SEE INSTRUCTIONS)			9,748,036	1,778		2,681,893	756 200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			9,748,036	1,778		2,681,893	756 202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-Z316)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT SUBJECT TO	COST SERVICES	COST SVCS NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.242016						50
53 ANESTHESIOLOGY	0.027388						53
54 RADIOLOGY-DIAGNOSTIC	0.235829						54
60 LABORATORY	0.192931						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.102349						65
66 PHYSICAL THERAPY	0.350267						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.223477						71
72 IMPL. DEV. CHARGED TO PATIENT	0.797140						72
73 DRUGS CHARGED TO PATIENTS	0.425193						73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
88.02 RHC III							88.02
90 CLINIC	1.832596						90
91 EMERGENCY	0.289073						91
92 OBSERVATION BEDS	0.314837						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.475403						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5470) [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[] HOSPITAL	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[XX] SNF (14-5470)		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	4,917,318						50
53 ANESTHESIOLOGY	1,992,676						53
54 RADIOLOGY-DIAGNOSTIC	9,887,728			4,360			54
60 LABORATORY	6,729,939			19,984			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	1,521,184			11,952			65
66 PHYSICAL THERAPY	1,757,304			117,754			66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
71 MEDICAL SUPPLIES CHRGD TO P	1,859,324			29,255			71
72 IMPL. DEV. CHARGED TO PATIEN	1,622,206						72
73 DRUGS CHARGED TO PATIENTS	1,845,975			115,866			73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)	2,477,307						88
88.01 RHC II	266,145						88.01
88.02 RHC III	539,800						88.02
90 CLINIC	229,917						90
91 EMERGENCY	6,859,156						91
92 OBSERVATION BEDS	374,495						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	42,880,474			299,171			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [XX] SNF (14-5470) [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT SUBJECT TO	COST SERVICES SUBJECT TO	COST SVCS NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.242016						50
53 ANESTHESIOLOGY	0.027388						53
54 RADIOLOGY-DIAGNOSTIC	0.235829						54
60 LABORATORY	0.192931						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.102349						65
66 PHYSICAL THERAPY	0.350267						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.223477						71
72 IMPL. DEV. CHARGED TO PATIENT	0.797140						72
73 DRUGS CHARGED TO PATIENTS	0.425193						73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
88.02 RHC III							88.02
90 CLINIC	1.832596						90
91 EMERGENCY	0.289073						91
92 OBSERVATION BEDS	0.314837						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.475403						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

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	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	198,330	58,656	139,674	1,430	97.67	90	8,790	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY	286,440		286,440	26,632	10.76	16,488	177,411	44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	484,770		426,114	28,062		16,578	186,201	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL
	COST	CHARGES	COST TO		
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x
	B, PT. II,	C, PT. I,	(COL.1 ÷	CHARGES	COL.4)
	COL. 26)	COL. 8)	COL.2)		
	1	2	3	4	5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	105,562	4,917,318	0.021467		50
53 ANESTHESIOLOGY	2,385	1,992,676	0.001197		53
54 RADIOLOGY-DIAGNOSTIC	217,166	9,887,728	0.021963		54
60 LABORATORY	100,390	6,729,939	0.014917		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	24,983	1,521,184	0.016423		65
66 PHYSICAL THERAPY	49,225	1,757,304	0.028012		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PA	40,519	1,859,324	0.021792		71
72 IMPL. DEV. CHARGED TO PATIENT	52,510	1,622,206	0.032370		72
73 DRUGS CHARGED TO PATIENTS	40,356	1,845,975	0.021862		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	138,351	2,477,307	0.055847		88
88.01 RHC II	13,476	266,145	0.050634		88.01
88.02 RHC III	15,791	539,800	0.029253		88.02
90 CLINIC	41,043	229,917	0.178512		90
91 EMERGENCY	148,647	6,859,156	0.021671		91
92 OBSERVATION BEDS	19,833	374,495	0.052959		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-199)	1,010,237	42,880,474	42,880,474		200

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

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	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

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	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	1,430		90		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY	26,632		16,488		44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	28,062		16,578		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	HEALTH 3	COST (SUM OF COLS.1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX]	HOSPITAL (14-1316)	[]	SUB (OTHER)	[]	ICF/MR	[]	PPS
APPLICABLE	[] TITLE XVIII-PT A	[]	IPF	[]	SNF	[]		[]	TEFRA
BOXES	[XX] TITLE XIX	[]	IRF	[]	NF	[]		[XX]	OTHER
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)		
	7	8	9	10	11	12	13		
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	4,917,318							50
53	ANESTHESIOLOGY	1,992,676							53
54	RADIOLOGY-DIAGNOSTIC	9,887,728							54
60	LABORATORY	6,729,939							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	1,521,184							65
66	PHYSICAL THERAPY	1,757,304							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
71	MEDICAL SUPPLIES CHRGED TO P	1,859,324							71
72	IMPL. DEV. CHARGED TO PATIEN	1,622,206							72
73	DRUGS CHARGED TO PATIENTS	1,845,975							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
88	RURAL HEALTH CLINIC (RHC)	2,477,307							88
88.01	RHC II	266,145							88.01
88.02	RHC III	539,800							88.02
90	CLINIC	229,917							90
91	EMERGENCY	6,859,156							91
92	OBSERVATION BEDS	374,495							92
OTHER REIMBURSABLE COST CENTERS									
95	AMBULANCE SERVICES	1,282,742							95
200	TOTAL (SUM OF LINES 50-199)	42,880,474							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	COST REIMB.	COST REIMB.	COST	COST		
	CHARGE RATIO	PPS	SVCES NOT	SVCES NOT	SVCES NOT	SVCES NOT	SVCES NOT
	FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO
	PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.242016						50
53 ANESTHESIOLOGY	0.027388						53
54 RADIOLOGY-DIAGNOSTIC	0.235829						54
60 LABORATORY	0.192931						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.102349						65
66 PHYSICAL THERAPY	0.350267						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.223477						71
72 IMPL. DEV. CHARGED TO PATIENT	0.797140						72
73 DRUGS CHARGED TO PATIENTS	0.425193						73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
88.01 RHC II							88.01
88.02 RHC III							88.02
90 CLINIC	1.832596						90
91 EMERGENCY	0.289073						91
92 OBSERVATION BEDS	0.314837						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.475403						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,094	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,430	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,430	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	187	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	403	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	23	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	51	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	807	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 (SEE INSTRUCTIONS)	159	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	266	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
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	117.40	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.40	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,674,198	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	2,700	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	5,987	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	495,148	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,179,050	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,648,130	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,648,130	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.715387	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,152.54	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,179,050	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 824.51 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 665,380 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 665,380 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 1,059,401 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 1,724,781 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 131,097 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUC (TITLE XVIII ONLY) 219,320 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 350,417 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 143 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 824.51 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 117,905 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	198,330	1,179,050	0.168212	117,905	19,833 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF (14-5470) TEFRA
 BOXES TITLE XIX-INPT IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	26,632	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	26,632	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	26,632	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	726	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 (SEE INSTRUCTIONS)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
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		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,791,390	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,791,390	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,403,144	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,403,144	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.114085	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	127.78	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,791,390	37

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

WORKSHEET D-1
PARTS III & IV

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[]	HOSPITAL	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[XX]	SNF (14-5470)	[]		[]	TEFRA
BOXES	[]	TITLE XIX-INPT	[]	IRF	[]	NF	[]		[]	OTHER

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	3,791,390	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	142.36	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	103,353	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	103,353	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	103,353	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	103,155	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	206,508	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-1316) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES TITLE XIX-INPT IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,094	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,430	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,430	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	187	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	403	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	23	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	51	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	90	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 (SEE INSTRUCTIONS)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
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	117.40	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.40	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,674,198	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	2,700	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	5,987	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	495,148	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,179,050	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,648,130	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,648,130	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.715387	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,152.54	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	1,179,050	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 824.51 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 74,206 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 74,206 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					74,206 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 8,790 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 8,790 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 143 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST					90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
30 INPATIENT ROUTINE SERVICE COST CENTERS					
ADULTS & PEDIATRICS		935,103			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.242016	221,579	53,626		50
53 ANESTHESIOLOGY	0.027388				53
54 RADIOLOGY-DIAGNOSTIC	0.235829	227,313	53,607		54
60 LABORATORY	0.192931	462,371	89,206		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.102349	165,196	16,908		65
66 PHYSICAL THERAPY	0.350267	66,607	23,330		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.223477	303,828	67,899		71
72 IMPL. DEV. CHARGED TO PATIENT	0.797140	709,214	565,343		72
73 DRUGS CHARGED TO PATIENTS	0.425193	437,213	185,900		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
90 CLINIC	1.832596				90
91 EMERGENCY	0.289073	12,390	3,582		91
92 OBSERVATION BEDS	0.314837				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,605,711	1,059,401		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,605,711			202

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z316) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.242016				50
53 ANESTHESIOLOGY	0.027388				53
54 RADIOLOGY-DIAGNOSTIC	0.235829	11,851	2,795		54
60 LABORATORY	0.192931	53,170	10,258		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.102349	28,402	2,907		65
66 PHYSICAL THERAPY	0.350267	170,777	59,818		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.223477	36,791	8,222		71
72 IMPL. DEV. CHARGED TO PATIENT	0.797140				72
73 DRUGS CHARGED TO PATIENTS	0.425193	127,912	54,387		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
90 CLINIC	1.832596				90
91 EMERGENCY	0.289073				91
92 OBSERVATION BEDS	0.314837				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		428,903	138,387		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		428,903			202

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [XX] SNF (14-5470) [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.242016				50
53 ANESTHESIOLOGY	0.027388				53
54 RADIOLOGY-DIAGNOSTIC	0.235829	4,360	1,028		54
60 LABORATORY	0.192931	19,984	3,856		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.102349	11,952	1,223		65
66 PHYSICAL THERAPY	0.350267	117,754	41,245		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.223477	29,255	6,538		71
72 IMPL. DEV. CHARGED TO PATIENT	0.797140				72
73 DRUGS CHARGED TO PATIENTS	0.425193	115,866	49,265		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
90 CLINIC	1.832596				90
91 EMERGENCY	0.289073				91
92 OBSERVATION BEDS	0.314837				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		299,171	103,155		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		299,171			202

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 03/29/2012 20:24

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.242016				50
53 ANESTHESIOLOGY	0.027388				53
54 RADIOLOGY-DIAGNOSTIC	0.235829				54
60 LABORATORY	0.192931				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.102349				65
66 PHYSICAL THERAPY	0.350267				66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PATI	0.223477				71
72 IMPL. DEV. CHARGED TO PATIENT	0.797140				72
73 DRUGS CHARGED TO PATIENTS	0.425193				73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
90 CLINIC	1.832596				90
91 EMERGENCY	0.289073				91
92 OBSERVATION BEDS	0.314837				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)					200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)					202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL (14-1316) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,682,649	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	2,682,649	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	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)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	2,709,475	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	8,951	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,524,103	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	1,176,421	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	1,176,421	30
31	PRIMARY PAYER PAYMENTS	118	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,176,303	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	303,757	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	303,757	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	1,480,060	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	1,480,060	40
41	INTERIM PAYMENTS	1,732,176	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-252,116	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF
 SUB (OTHER) SNF (14-5470)

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	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)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)		40
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-1316) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

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		939,803		1,575,039	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.		18,779		305,115	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 03/11/2011	100,471	03/11/2011	143,690	3.01
	.02 09/09/2011	228,902			3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE	09/09/2011	291,668	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99	329,373		-147,978	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,287,955		1,732,176	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	251,916			6.01
	TO PROVIDER .02			-252,116	6.02
	PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,539,871		1,480,060	7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [] SNF [XX] SWING BED SNF (14-Z316)	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			422,807		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 ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99	03/11/2011 09/09/2011 03/12/2010	15,048 15,261 7,392		NONE 3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			22,917		
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			445,724		4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99		NONE NONE		NONE 5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	.01 .02		40,564		6.01 6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			486,288		7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		DATE:

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF (14-5470)
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

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		113,839		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 ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		113,839		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE	NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01 TO PROVIDER .02 PROVIDER .02 TO PROGRAM .02			6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		113,839		7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK
APPLICABLE BOX

HOSPITAL (14-1316) CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	503	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	807	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,287	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	50,854,692	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,707,928	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2010 TO 09/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
03/29/2012 20:24

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z316)
APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	353,921	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	139,771	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	425	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	493,692	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	493,692	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	493,692	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	7,404	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	486,288	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	486,288	19
20 INTERIM PAYMENTS	445,724	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	40,564	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

CHECK [XX] HOSPITAL (14-1316)
APPLICABLE BOX: [] SUB (OTHER)

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	INPATIENT SERVICES	1,724,781	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,724,781	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,742,029	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		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 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	1,742,029	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	235,020	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,507,009	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,507,009	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	32,862	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	32,862	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,539,871	28
29	OTHER ADJUSTMENTS (LOSS ON SALE OF ASSETS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,539,871	30
31	INTERIM PAYMENTS	1,287,955	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	251,916	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

PROSPECTIVE PAYMENT AMOUNT			
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	159,364	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (SUM OF LINES 1-3)	159,364	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	MEDICAL AND OTHER SERVICES		5
6	DEDUCTIBLES		6
7	COINSURANCE	45,525	7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
10	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	113,839	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (CALCULATION ERROR ON WORKSHEET S-7)		14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	113,839	15
16	INTERIM PAYMENTS	113,839	16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)		18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-1316) [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	74,206	1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	74,206	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	74,206	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES		8
9	ANCILLARY SERVICE CHARGES		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)		15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	74,206	21
PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS		22
23	OUTLIER PAYMENTS		23
24	PROGRAM CAPITAL PAYMENTS		24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29	SUM OF LINES 27 AND 21	74,206	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (FROM LINE 18)		30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	74,206	31
32	DEDUCTIBLES		32
33	COINSURANCE		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	UTILIZATION REVIEW		35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	74,206	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)	74,206	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	74,206	40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	74,206	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

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	817,550			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	8,995,133			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-6,363,985			6
7	INVENTORY	245,659			7
8	PREPAID EXPENSES	153,488			8
9	OTHER CURRENT ASSETS	110,000			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	3,957,845			11
FIXED ASSETS					
12	LAND	486,970			12
13	LAND IMPROVEMENTS	72,519			13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	10,431,603			15
16	ACCUMULATED DEPRECIATION	-4,387,849			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	4,569,031			23
24	ACCUMULATED DEPRECIATION	-3,133,912			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	8,038,362			30
OTHER ASSETS					
31	INVESTMENTS	3,565,398			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS	291,490			33
34	OTHER ASSETS	4,207,642			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	8,064,530			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	20,060,737			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	2,387,063			37
38	SALARIES, WAGES & FEES PAYABLE				38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	610,366			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	1,980,174			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,977,603			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	8,610,473			46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	135,779			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	8,746,252			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	13,723,855			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	6,336,882			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	6,336,882			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	20,060,737			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		5,868,632							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		468,250							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		6,336,882							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		6,336,882							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		6,336,882							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	2,031,554		2,031,554	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	682,556		682,556	6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY	3,977,336		3,977,336	8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	6,691,446		6,691,446	11
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
TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	6,691,446		6,691,446	18
18 ANCILLARY SERVICES	6,761,731	33,213,760	39,975,491	19
19 OUTPATIENT SERVICES				20
20 RHC		2,477,307	2,477,307	20.01
20.01 RHC II		266,145	266,145	20.02
20.02 RHC III		539,800	539,800	21
21 FQHC				22
22 HOME HEALTH AGENCY				23
23 AMBULANCE		1,282,742	1,282,742	25
25 ASC				26
26 HOSPICE				27
27 PROFESSIONAL FEES	29,086	488,480	517,566	28
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	13,482,263	38,268,234	51,750,497	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		22,061,778	29
30 ADD (SPECIFY)	1,931,978		30
31 BAD DEBTS			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		1,931,978	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		23,993,756	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	51,750,497	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	27,832,322	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	23,918,175	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	23,993,756	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-75,581	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	30,405	6
7	INCOME FROM INVESTMENTS	79,591	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	26,905	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE 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	5,372	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	10,564	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (TRUST INCOME)	132,910	24
24.01	OTHER (MISCELLANEOUS INCOME)	19,697	24.01
24.02	OTHER (UNREALIZED GAINS)		24.02
24.03	OTHER (GRANTS)	74,267	24.03
24.04	OTHER (CATERING)	25,672	24.04
24.05	OTHER (MEDICAID ASSESSMENT REVENUE)		24.05
24.06	OTHER (COUNTY TERRACE)	485,323	24.06
24.07	OTHER (LOSS ON REFINANCING)	-346,875	24.07
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	543,831	25
26	TOTAL (LINE 5 PLUS LINE 25)	468,250	26
27	OTHER EXPENSES (LOSS ON DISPOSAL)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	468,250	29

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
44 SKILLED NURSING FACILITY					44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
193.01 ASSISTED LIVING					193.01
194 FOUNDATION					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

RHC I
 COMPONENT NO: 14-3448

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	2.04	21,120	4,200	8,568	1
2	PHYSICIAN ASSISTANTS	3.00		2,100	6,300	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	5.04	21,120		14,868	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5.04	21,120			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,874,980	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,874,980	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)					14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,075,899	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,075,899	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,075,899	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,075,899	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				2,950,879	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3448

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)		2,950,879	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)		68,740	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)		2,882,139	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)		21,120	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)			5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)		21,120	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)		136.46	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	136.46	136.46	136.46	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,347	3,291		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	183,812	449,090		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)				15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	183,812	449,090		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		311,641		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	147,050	311,641		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		59,539		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		458,691		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		35,217		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		493,908		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		16,040		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		509,948		26
27	INTERIM PAYMENTS		421,218		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		88,730		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

(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

RHC I
 COMPONENT NO: 14-3448

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,874,980	1,874,980	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.018577	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		34,832	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)		8,845	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		43,677	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,874,980	1,874,980	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,075,899	1,075,899	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.023295	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		25,063	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		68,740	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		931	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		73.83	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		477	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		35,217	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		68,740	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		35,217	16

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 APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		407,981	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 ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 03/11/2011	13,237	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
	.99	13,237	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		421,218	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
	.99		5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)			
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01	88,730	6.01
	PROVIDER PROVIDER TO .02		6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		509,948	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	DATE:

RHC II
 COMPONENT NO: 14-3485

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10	190,319	38,650	228,969		228,969		228,969	10
SUBTOTAL (SUM OF LINES 1-9)								
11	190,319	38,650	228,969		228,969		228,969	11
COSTS UNDER AGREEMENT								
12								12
13								13
14								14
SUBTOTAL (SUM OF LINES 11-13)								
15								15
OTHER HEALTH CARE COSTS								
16								16
17								17
18								18
19								19
20								20
21								21
22	190,319	38,650	228,969		228,969		228,969	22
SUBTOTAL (SUM OF LINES 15-20)								
23								23
24								24
25								25
26								26
27								27
28								28
TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								
FACILITY OVERHEAD								
29								29
30								30
31								31
32	190,319	38,650	228,969		228,969		228,969	32
SUBTOTAL (SUM OF LINES 22, 28 AND 31)								

RHC II
 COMPONENT NO: 14-3485

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS		4,200			1
2	PHYSICIAN ASSISTANTS	0.40	2,095	840		2
3	NURSE PRACTITIONERS		2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	0.40	2,095	840	2,095	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.40	2,095		2,095	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				228,969	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				228,969	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)					14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				102,897	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				102,897	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				102,897	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				102,897	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				331,866	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC II
 COMPONENT NO: 14-3485

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	331,866	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	9,311	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	322,555	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	2,095	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,095	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	153.96	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	153.96	153.96	153.96	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	188	391		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	28,944	60,198		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)				15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	28,944	60,198		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		41,910		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	23,155	41,910		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		7,811		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		65,065		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		4,056		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		69,121		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		678		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		144		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		69,799		26
27	INTERIM PAYMENTS		66,312		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		3,487		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

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

RHC II
 COMPONENT NO: 14-3485

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	228,969	228,969	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.017104	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		3,916	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)		2,508	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		6,424	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	228,969	228,969	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	102,897	102,897	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.028056	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		2,887	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		9,311	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		264	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		35.27	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		115	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		4,056	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		9,311	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		4,056	16

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 APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		63,344	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 ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 03/11/2011	2,968	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
	.99	2,968	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		66,312	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
	.99		5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)			
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01	3,487	6.01
	PROVIDER PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		69,799	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	DATE:

RHC III
 COMPONENT NO: 14-3496

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 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	218,129	75,337	293,466	-21,206	272,260		272,260	9
10 SUBTOTAL (SUM OF LINES 1-9)	218,129	75,337	293,466	-21,206	272,260		272,260	10
COSTS UNDER AGREEMENT								
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)								14
OTHER HEALTH CARE COSTS								
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 (SUM OF LINES 10, 14, AND 21)	218,129	75,337	293,466	-21,206	272,260		272,260	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS								30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)								31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	218,129	75,337	293,466	-21,206	272,260		272,260	32

RHC III
 COMPONENT NO: 14-3496

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
1	1	2	3	4	5	1
2	0.50	5,523	4,200	2,100		2
3			2,100			3
4	0.50	5,523	2,100	2,100	5,523	4
5						5
6						6
7						7
8	0.50	5,523			5,523	8
9						9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10					272,260	10
11						11
12					272,260	12
13					1.000000	13
14						14
15					116,615	15
16					116,615	16
17						17
18					116,615	18
19					116,615	19
20					388,875	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC III
 COMPONENT NO: 14-3496

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	388,875	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	9,450	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	379,425	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	5,523	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,523	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	68.70	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	68.70	68.70	68.70	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	277	711		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	19,030	48,846		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)				15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	19,030	48,846		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		24,458		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	15,224	24,458		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		18,273		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		39,682		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		1,955		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		41,637		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)				23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		1,216		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		41,637		26
27	INTERIM PAYMENTS		47,172		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		-5,535		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

(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

RHC III
 COMPONENT NO: 14-3496

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	272,260	272,260	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.016204	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		4,412	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)		2,204	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		6,616	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	272,260	272,260	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	116,615	116,615	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.024300	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		2,834	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		9,450	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		232	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		40.73	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		48	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		1,955	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		9,450	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		1,955	16

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 APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		45,076	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 ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 03/12/2010	2,096	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
	.99		3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		2,096	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		47,172	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
	.99		5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)			
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01		6.01
	PROVIDER PROVIDER TO .02	-5,535	6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		41,637	7
8 NAME OF CONTRACTOR:	CONTRACTOR NUMBER:		DATE: