

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: 02-25-2013 TIME: 11:20
 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 10/01/2011 AND ENDING 09/30/2012, 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, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		8,599	-285,822		105,077	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		100,985				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY		1				7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			157,002			10
10.01 HEALTH CLINIC - RHC II			-869			10.01
10.02 HEALTH CLINIC - RHC III			28,473			10.02
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		109,585	-101,216		105,077	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 H	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: 10/01/2011 TO: 09/30/2012									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	2	
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	N
												N

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6				
									24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID 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.								2	26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.								2	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.			BEGINNING:		ENDING:				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.			BEGINNING:		ENDING:				38	
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)									1	2
										N	N

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

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

'N' FOR NO.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	56
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.	N			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.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, 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)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, 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					
1	PROGRAM CODE	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					
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)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	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 1	PROGRAM CODE 2	UNWEIGHTED FTEs NONPROVIDER SITE 3	UNWEIGHTED FTEs IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			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? ENTER 'Y' FOR YES OR 'N' FOR NO.			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- Y Y	RESPI- SICAL ATIONAL SPEECH RATORY 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. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	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
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 208,769 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). 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.	1 N	2	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, LINE 74 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)

	TITLE XVIII		TITLE XIX	
	PART A	PART B	V	XIX
155	HOSPITAL	N	3	4
156	SUBPROVIDER - IPF	N		N
157	SUBPROVIDER - IRF	N		157
158	SUBPROVIDER - (OTHER)	N		158
159	SNF	N		159
160	HHA	N		160
161	CMHC	N		161

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

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
FINANCIAL DATA AND REPORTS				
		Y/N	TYPE	DATE
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
APPROVED EDUCATIONAL ACTIVITIES				
		Y/N	Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	6
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
PS&R REPORT DATA				
		Y/N	DATE	Y/N
		1	2	3
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	01/04/2013	Y
		4		
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

COST REPORT PREPARER CONTACT INFORMATION

- 41 FIRST NAME: GARY LAST NAME: ZEMAN TITLE: SENIOR MGR. 41
- 42 EMPLOYER: STRATEGIC REIMBURSEMENT, INC. 42
- 43 PHONE NUMBER: 630-530-7100 EXT. 112 E-MAIL ADDRESS: GARY.ZEMAN@SRINC.ORG 43

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	TOTAL SALARIES (SEE INSTRUCTIONS)	200	9,745,613	-241,518	494,882.00	1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A ADMINISTRATIVE					4
4.01	PHYSICIAN-PART A - TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44	1,392,841	-724	87,624.00	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		894,999	-7,117	51,986.00	10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)		315,609		6,174.00	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE					15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING WAGE-RELATED COSTS					16
17	WAGE-RELATED COSTS (CORE)		1,434,005			17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS		708,920			19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A - ADMINISTRATIVE					22
22.01	PHYSICIAN PART A - TEACHING					22.01
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM) OVERHEAD COSTS - DIRECT SALARIES					25
26	EMPLOYEE BENEFITS		106,614		3,033.00	26
27	ADMINISTRATIVE & GENERAL		850,803	108,620	40,771.00	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		270,547		17,996.00	30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING		267,392		26,789.00	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		397,762		35,339.00	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION		108,082		2,080.00	38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		147,649		9,149.00	41
42	SOCIAL SERVICE		49,093		2,465.00	42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	9,745,613	-241,518	9,504,095	494,882.00	19.20	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2,287,840	-7,841	2,279,999	139,610.00	16.33	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7,457,773	-233,677	7,224,096	355,272.00	20.33	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	315,609		315,609	6,174.00	51.12	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	1,434,005		1,434,005		19.85%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	9,207,387	-233,677	8,973,710	361,446.00	24.83	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	2,197,942	108,620	2,306,562	137,622.00	16.76	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
RETIREMENT COST			
1	401K EMPLOYER CONTRIBUTIONS	61,966	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		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)	1,183,025	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	102,136	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	677,127	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	118,669	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER			
21	EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,142,923	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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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 1	DATE 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 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 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	3		3 10
11	RLX			11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB			16
17	RVA	3		3 17
18	RHC	2		2 18
19	RHB	29		29 19
20	RHA	284		284 20
21	RMC	129		129 21
22	RMB	137		137 22
23	RMA	420		420 23
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1	14		14 28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1	7		7 32
33	HC2	14		14 33
34	HC1	3		3 34
35	HB2	14		14 35
36	HB1	51		51 36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2	9		9 41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1	14		14 48
49	CC2	29		29 49
50	CC1	18		18 50
51	CB2			51
52	CB1	26		26 52
53	CA2			53
54	CA1	69		69 54
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	31		31 66
67	BA2			67
68	BA1	8		8 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		14		14 70
71	PD2				71
72	PD1		11		11 72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1		30		30 76
77	PA2				77
78	PA1		19		19 78
199	AAA				199
200	TOTAL		1,388		1,388 200

		CBSA AT	CBSA ON/AFTER	
		BEGINNING	OCT 1 OF THE	
		OF COST	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)	5,427,534			207

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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

4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 1 2 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? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. 1 2 10
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		TOTAL
	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 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 IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 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 TOTAL 15

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. 1 2 10
N

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

11 CLINIC

(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 12
N

13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? 1 2 13
N

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

	Y/N	V	XVIII	XIX	TOTAL	
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 IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)	N					15

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 202, COL. 3 DIVIDED BY LINE 202, COL. 8)			0.391252	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)					
2	NET REVENUE FROM MEDICAID			3,945,028	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			11,235,963	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)			4,396,093	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.			451,065	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) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.				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) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.				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)			451,065	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 FACILITY	967,981		967,981	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	378,725		378,725	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	378,725		378,725	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)			1,610,375	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			466,328	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,144,047	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			447,611	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			826,336	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			1,277,401	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				137,323	1
2	00200		1,264,274	1,264,274	3,031	2
3	00300					3
4	00400	106,614	37,864	144,478	1,112,580	4
5	00500	850,803	6,067,826	6,918,629	-998,625	5
6	00600					6
7	00700	270,547	1,798,541	2,069,088	18,168	7
8	00800		117,562	117,562		8
9	00900	267,392	53,277	320,669		9
10	01000	397,762	315,265	713,027		10
11	01100					11
12	01200					12
13	01300	108,082	11,174	119,256		13
14	01400					14
15	01500					15
16	01600	147,649	46,535	194,184		16
17	01700	49,093	3,305	52,398		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	671,666	110,941	782,607	806	30
44	04400	1,392,841	396,451	1,789,292	30,579	44
ANCILLARY SERVICE COST CENTERS						
50	05000	364,579	1,109,519	1,474,098	-709,526	50
53	05300	241,518	38,843	280,361		53
54	05400	518,266	1,025,905	1,544,171		54
60	06000	372,391	532,761	905,152		60
62.30	06250					62.30
65	06500		50,484	50,484		65
66	06600	93,307	358,491	451,798		66
67	06700					67
68	06800					68
69	06900		57,410	57,410		69
71	07100		202,099	202,099		71
72	07200				709,526	72
73	07300	5,019	557,369	562,388		73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	1,784,036	947,701	2,731,737	-216,235	88
88.01	08801	183,937	37,048	220,985		88.01
88.02	08802	253,412	124,659	378,071	-29,550	88.02
90	09000	46,250	119,473	165,723		90
91	09100	725,450	1,232,101	1,957,551	-75,919	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	424,220	137,548	561,768		95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
118		9,274,834	16,754,426	26,029,260	-17,842	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
193.01	19301	169,881	33,095	202,976	49,423	193.01
193.02	19302	300,898	143,044	443,942	-31,581	193.02
194	07950					194
200		9,745,613	16,930,565	26,676,178		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	137,323		94,070	1
2	00200	1,267,305	-43,253	1,267,305	2
3	00300				3
4	00400	1,257,058	-15,000	1,242,058	4
5	00500	5,920,004	-1,691,914	4,228,090	5
6	00600				6
7	00700	2,087,256		2,087,256	7
8	00800	117,562		117,562	8
9	00900	320,669		320,669	9
10	01000	713,027	-27,789	685,238	10
11	01100				11
12	01200				12
13	01300	119,256		119,256	13
14	01400				14
15	01500				15
16	01600	194,184	-4,301	189,883	16
17	01700	52,398		52,398	17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	783,413		783,413	30
44	04400	1,819,871		1,819,871	44
ANCILLARY SERVICE COST CENTERS					
50	05000	764,572		764,572	50
53	05300	280,361	-241,518	38,843	53
54	05400	1,544,171		1,544,171	54
60	06000	905,152		905,152	60
62.30	06250				62.30
65	06500	50,484		50,484	65
66	06600	451,798		451,798	66
67	06700				67
68	06800				68
69	06900	57,410		57,410	69
71	07100	202,099		202,099	71
72	07200	709,526		709,526	72
73	07300	562,388		562,388	73
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
88	08800	2,515,502	-198,200	2,317,302	88
88.01	08801	220,985	-5,900	215,085	88.01
88.02	08802	348,521	-15,723	332,798	88.02
90	09000	165,723		165,723	90
91	09100	1,881,632	-737,015	1,144,617	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
95	09500	561,768		561,768	95
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
118		26,011,418	-2,980,613	23,030,805	118
NONREIMBURSABLE COST CENTERS					
190	19000				190
193.01	19301	252,399		252,399	193.01
193.02	19302	412,361		412,361	193.02
194	07950				194
200		26,676,178	-2,980,613	23,695,565	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			200,651 1
500 TOTAL RECLASSIFICATIONS						200,651 500
CODE LETTER - A						
1 RENT EXPENSE	B	CAP REL COSTS-MVBLE EQUIP	2			3,031 1
500 TOTAL RECLASSIFICATIONS						3,031 500
CODE LETTER - B						
1 CAPITAL INSURANCE	C	CAP REL COSTS-BLDG & FIXT	1			60,739 1
500 TOTAL RECLASSIFICATIONS						60,739 500
CODE LETTER - C						
1 UTILITY EXPENSE	D	OPERATION OF PLANT	7			18,168 1
2						2
500 TOTAL RECLASSIFICATIONS						18,168 500
CODE LETTER - D						
1 ACTIVITIES THERAPY	E	ADULTS & PEDIATRICS	30		724	82 1
500 TOTAL RECLASSIFICATIONS					724	82 500
CODE LETTER - E						
1 INSURANCE EXPENSE	F	ADMINISTRATIVE & GENERAL	5			234,529 1
2						2
3						3
500 TOTAL RECLASSIFICATIONS						234,529 500
CODE LETTER - F						
1 CRNA SALARIES	G	ANESTHESIOLOGY	53			241,518 1
500 TOTAL RECLASSIFICATIONS						241,518 500
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		234,225	56,759 1
2						2
3						3
500 TOTAL RECLASSIFICATIONS					234,225	56,759 500
CODE LETTER - I						
1 RHC SPECIALTY PHYSICIAN	J	RURAL HEALTH CLINIC (RHC)	88		125,605	17,026 1
500 TOTAL RECLASSIFICATIONS					125,605	17,026 500
CODE LETTER - J						
1 BENEFITS	K	EMPLOYEE BENEFITS	4			1,112,580 1
500 TOTAL RECLASSIFICATIONS						1,112,580 500
CODE LETTER - K						
1 SURGERY SUPPLIES	L	IMPL. DEV. CHARGED TO PATIENT	72			709,526 1
500 TOTAL RECLASSIFICATIONS						709,526 500
CODE LETTER - L						
GRAND TOTAL (INCREASES)					360,554	2,778,676

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	5		200,651	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					200,651	500
1 RENT EXPENSE	B	SKILLED NURSING FACILITY	44		3,031	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					3,031	500
1 CAPITAL INSURANCE	C	ADMINISTRATIVE & GENERAL	5		60,739	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					60,739	500
1 UTILITY EXPENSE	D	ADMINISTRATIVE & GENERAL	5		7,537	1
2 SKILLED NURSING FACILITY			44		10,631	2
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					18,168	500
1 ACTIVITIES THERAPY	E	SKILLED NURSING FACILITY	44	724	82	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E				724	82	500
1 INSURANCE EXPENSE	F	EMERGENCY	91		75,919	1
2 RURAL HEALTH CLINIC (RHC)			88		136,386	2
3 WATSEKA CLINIC			193.02		22,224	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					234,529	500
1 CRNA SALARIES	G	ANESTHESIOLOGY	53	241,518		1
500 TOTAL RECLASSIFICATIONS CODE LETTER - G				241,518		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	WATSEKA CLINIC	193.02	7,117	2,240	1
2 RURAL HEALTH CLINIC (RHC)			88	204,936	47,141	2
3 RHC III			88.02	22,172	7,378	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - I				234,225	56,759	500
1 RHC SPECIALTY PHYSICIAN	J	ADMINISTRATIVE & GENERAL	5	125,605	17,026	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - J				125,605	17,026	500
1 BENEFITS	K	ADMINISTRATIVE & GENERAL	5		1,112,580	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - K					1,112,580	500
1 SURGERY SUPPLIES	L	OPERATING ROOM	50		709,526	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - L					709,526	500
GRAND TOTAL (DECREASES)				602,072	2,537,158	

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)	
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP	1,264,274						1,264,274	2
3 TOTAL (SUM OF LINES 1-2)	1,264,274						1,264,274	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)	
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)	
1 CAP REL COSTS-BLDG & FIXT	-115,907		209,977				94,070	1
2 CAP REL COSTS-MVBLE EQUIP	1,264,274		3,031				1,267,305	2
3 TOTAL	1,148,367		213,008				1,361,375	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	-2,025	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 CAFETERIA - EMPLOYEES AND GUESTS	B	-6,445	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	-4,301	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		RESPIRATORY THERAPY	65	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	-21,344	DIETARY	10	33
33					34
34 LOBBYING EXPENSE	A	-6,652	ADMINISTRATIVE & GENERAL	5	35
35					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	-7,044	ADMINISTRATIVE & GENERAL	5	40
40 MISCELLANEOUS REVENUE	B	-2,623	RURAL HEALTH CLINIC (RHC)	88	41
41 CLINIC MEDICAL RECORDS	B	-972	RURAL HEALTH CLINIC (RHC)	88	42
42 CRNA SALARIES	A	-241,518	ANESTHESIOLOGY	53	43
43 CRNA BENEFITS	A	-15,000	EMPLOYEE BENEFITS	4	43.01
44 BAD DEBTS	A	-1,623,383	ADMINISTRATIVE & GENERAL	5	44
44.01 BAD DEBTS	A	-194,605	RURAL HEALTH CLINIC (RHC)	88	44.01
44.02 BAD DEBTS	A	-5,900	RHC II	88.01	44.02
44.03 BAD DEBTS	A	-15,723	RHC III	88.02	44.03
45 UNNECESSARY BORROWING	A	-49,388	CAP REL COSTS-BLDG & FIXT	1	11 45
45.02 POB LAPSING SCHEDULE	A	8,160	CAP REL COSTS-BLDG & FIXT	1	9 45.02
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-2,980,613			50

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

WORKSHEET A-8-1

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

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

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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
1	2	3	4	5	6	7	8	9
4	91 EMERGENCY	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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.		12	13	14	15	16	17	18	
4	91 EMERGENCY								737,015
200	TOTAL								737,015 4 200

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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		415.00	1,798.00			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					29,560	15
16	ASSISTANTS					96,067	16
17	SUBTOTAL ALLOWANCE AMOUNT					125,627	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					125,627	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					125,627	23

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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					125,627	57
58					12,600	58
59						59
60						60
61						61
62						62
63					138,227	63
64					101,666	64
65						65

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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		2,095.00	1,696.00			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					149,227	15
16	ASSISTANTS					90,617	16
17	SUBTOTAL ALLOWANCE AMOUNT					239,844	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					239,844	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					239,844	23

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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					239,844	57
58					10,999	58
59						59
60						60
61						61
62						62
63					250,843	63
64					203,154	64
65						65

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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		153.00				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					10,898	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					10,898	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					10,898	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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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					9,686	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	94,070	94,070				1
2 CAP REL COSTS-MVBLE EQUIP	1,267,305		1,267,305			2
4 EMPLOYEE BENEFITS	1,242,058			1,242,058		4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	4,228,090	50,178	675,988	126,806	5,081,062	5
6 OPERATION OF PLANT	2,087,256	5,319	71,662	35,758	2,199,995	7
8 LAUNDRY & LINEN SERVICE	117,562	1,514	20,391		139,467	8
9 HOUSEKEEPING	320,669	1,209	16,284	35,341	373,503	9
10 DIETARY	685,238	4,722	63,618	52,572	806,150	10
11 CAFETERIA		768	10,342		11,110	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	119,256	1,250	16,846	14,285	151,637	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	189,883	1,532	20,636	19,515	231,566	16
17 SOCIAL SERVICE	52,398	546	7,359	6,489	66,792	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	783,413	5,472	73,716	88,869	951,470	30
44 SKILLED NURSING FACILITY	1,819,871			183,995	2,003,866	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	764,572	2,840	38,264	48,186	853,862	50
53 ANESTHESIOLOGY	38,843				38,843	53
54 RADIOLOGY-DIAGNOSTIC	1,544,171	6,479	87,286	68,499	1,706,435	54
60 LABORATORY	905,152	2,401	32,347	49,219	989,119	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	50,484	889	11,980		63,353	65
66 PHYSICAL THERAPY	451,798	1,214	16,357	12,332	481,701	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	57,410				57,410	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	202,099	1,314	17,702		221,115	71
72 IMPL. DEV. CHARGED TO PATIENT	709,526				709,526	72
73 DRUGS CHARGED TO PATIENTS	562,388	456	6,137	663	569,644	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)	2,317,302			225,309	2,542,611	88
88.01 RHC II	215,085			24,311	239,396	88.01
88.02 RHC III	332,798			30,563	363,361	88.02
90 CLINIC	165,723	1,301	17,530	6,113	190,667	90
91 EMERGENCY	1,144,617	2,971	40,024	95,882	1,283,494	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	561,768			56,069	617,837	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)	23,030,805	92,375	1,244,469	1,180,776	22,944,992	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,695	22,836		24,531	190
193.01 ASSISTED LIVING	252,399			22,453	274,852	193.01
193.02 WATSEKA CLINIC	412,361			38,829	451,190	193.02
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	23,695,565	94,070	1,267,305	1,242,058	23,695,565	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	5,081,062					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	600,517	2,800,512				7
8 LAUNDRY & LINEN SERVICE	38,069	31,187	208,723			8
9 HOUSEKEEPING	101,952	24,905		500,360		9
10 DIETARY	220,049	97,301		17,512	1,141,012	10
11 CAFETERIA	3,033	15,818		2,847	172,752	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	41,391	25,765		4,637		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	63,209	31,561		5,680		16
17 SOCIAL SERVICE	18,232	11,256		2,026		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	259,716	112,744	76,617	20,292	46,824	30
44 SKILLED NURSING FACILITY	546,981	1,063,424	76,528	191,394	695,810	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	233,073	58,522		10,533		50
53 ANESTHESIOLOGY	10,603					53
54 RADIOLOGY-DIAGNOSTIC	465,794	133,498		24,027		54
60 LABORATORY	269,993	49,473		8,904		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	17,293	18,323		3,298		65
66 PHYSICAL THERAPY	131,487	25,017	8,401	4,503		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	15,671					69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	60,356	27,074		4,873		71
72 IMPL. DEV. CHARGED TO PATIENT	193,674					72
73 DRUGS CHARGED TO PATIENTS	155,492	9,386		1,689		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)	694,031	362,727		65,283		88
88.01 RHC II	65,346					88.01
88.02 RHC III	99,184					88.02
90 CLINIC	52,045	26,812		4,826		90
91 EMERGENCY	350,346	61,215		11,017		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	168,647					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)	4,876,184	2,186,008	161,546	383,341	915,386	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,696			6,286		190
193.01 ASSISTED LIVING	75,024	614,504	47,177	110,733	225,626	193.01
193.02 WATSEKA CLINIC	123,158					193.02
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	5,081,062	2,800,512	208,723	500,360	1,141,012	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	205,560						11
12 MAINTENANCE OF PERSONNEL							12
13 NURSING ADMINISTRATION		223,430					13
14 CENTRAL SERVICES & SUPPLY							14
15 PHARMACY							15
16 MEDICAL RECORDS & LIBRARY	6,630		338,646				16
17 SOCIAL SERVICE	1,786			100,092			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	21,765	82,343	67,291	18,821	1,657,883		30
44 SKILLED NURSING FACILITY	63,236	46,817	19,874	81,271	4,789,201		44
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	18,321	31,918	22,378		1,228,607		50
53 ANESTHESIOLOGY	1,507				50,953		53
54 RADIOLOGY-DIAGNOSTIC	17,812		53,207		2,400,773		54
60 LABORATORY	13,310		37,558		1,368,357		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY			31,298		133,565		65
66 PHYSICAL THERAPY	8,104		16,432		675,645		66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY					73,081		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					313,418		71
72 IMPL. DEV. CHARGED TO PATIENT					903,200		72
73 DRUGS CHARGED TO PATIENTS	199				736,410		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)	16,381		24,413		3,705,446		88
88.01 RHC II					304,742		88.01
88.02 RHC III					462,545		88.02
90 CLINIC	2,380				276,730		90
91 EMERGENCY	24,445	62,352	65,413		1,858,282		91
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES			782		787,266		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)	195,876	223,430	338,646	100,092	21,726,104		118
NONREIMBURSABLE COST CENTERS							
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					37,513		190
193.01 ASSISTED LIVING	9,684				1,357,600		193.01
193.02 WATSEKA CLINIC					574,348		193.02
194 FOUNDATION							194
200 CROSS FOOT ADJUSTMENTS							200
201 NEGATIVE COST CENTER							201
202 TOTAL (SUM OF LINES 118-201)	205,560	223,430	338,646	100,092	23,695,565		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	1,657,883		30
44 SKILLED NURSING FACILITY	4,789,201		44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	1,228,607		50
53 ANESTHESIOLOGY	50,953		53
54 RADIOLOGY-DIAGNOSTIC	2,400,773		54
60 LABORATORY	1,368,357		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY	133,565		65
66 PHYSICAL THERAPY	675,645		66
67 OCCUPATIONAL THERAPY			67
68 SPEECH PATHOLOGY			68
69 ELECTROCARDIOLOGY	73,081		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	313,418		71
72 IMPL. DEV. CHARGED TO PATIENT	903,200		72
73 DRUGS CHARGED TO PATIENTS	736,410		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)	3,705,446		88
88.01 RHC II	304,742		88.01
88.02 RHC III	462,545		88.02
90 CLINIC	276,730		90
91 EMERGENCY	1,858,282		91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
95 AMBULANCE SERVICES	787,266		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)	21,726,104		118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,513		190
193.01 ASSISTED LIVING	1,357,600		193.01
193.02 WATSEKA CLINIC	574,348		193.02
194 FOUNDATION			194
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)	23,695,565		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		50,178	675,988	726,166	726,166	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		5,319	71,662	76,981	85,824	7
8 LAUNDRY & LINEN SERVICE		1,514	20,391	21,905	5,441	8
9 HOUSEKEEPING		1,209	16,284	17,493	14,571	9
10 DIETARY		4,722	63,618	68,340	31,449	10
11 CAFETERIA		768	10,342	11,110	433	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		1,250	16,846	18,096	5,916	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		1,532	20,636	22,168	9,034	16
17 SOCIAL SERVICE		546	7,359	7,905	2,606	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		5,472	73,716	79,188	37,118	30
44 SKILLED NURSING FACILITY					78,173	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		2,840	38,264	41,104	33,310	50
53 ANESTHESIOLOGY					1,515	53
54 RADIOLOGY-DIAGNOSTIC		6,479	87,286	93,765	66,570	54
60 LABORATORY		2,401	32,347	34,748	38,587	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			889	11,980	12,869	65
66 PHYSICAL THERAPY		1,214	16,357	17,571	18,792	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY					2,240	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1,314	17,702	19,016	8,626	71
72 IMPL. DEV. CHARGED TO PATIENT					27,679	72
73 DRUGS CHARGED TO PATIENTS		456	6,137	6,593	22,222	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)					99,185	88
88.01 RHC II					9,339	88.01
88.02 RHC III					14,175	88.02
90 CLINIC		1,301	17,530	18,831	7,438	90
91 EMERGENCY		2,971	40,024	42,995	50,070	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES					24,102	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)		92,375	1,244,469	1,336,844	696,886	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,695	22,836	24,531	957	190
193.01 ASSISTED LIVING					10,722	193.01
193.02 WATSEKA CLINIC					17,601	193.02
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		94,070	1,267,305	1,361,375	726,166	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	162,805					7
8 LAUNDRY & LINEN SERVICE	1,813	29,159				8
9 HOUSEKEEPING	1,448		33,512			9
10 DIETARY	5,656		1,173	106,618		10
11 CAFETERIA	920		191	16,142	28,796	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,498		311			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,835		380		929	16
17 SOCIAL SERVICE	654		136		250	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	6,554	10,703	1,359	4,375	3,049	30
44 SKILLED NURSING FACILITY	61,820	10,691	12,820	65,018	8,859	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,402		705		2,567	50
53 ANESTHESIOLOGY					211	53
54 RADIOLOGY-DIAGNOSTIC	7,761		1,609		2,495	54
60 LABORATORY	2,876		596		1,864	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,065		221			65
66 PHYSICAL THERAPY	1,454	1,174	302		1,135	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,574		326			71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	546		113		28	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)	21,087		4,372		2,295	88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC	1,559		323		333	90
91 EMERGENCY	3,559		738		3,424	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)	127,081	22,568	25,675	85,535	27,439	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			421			190
193.01 ASSISTED LIVING	35,724	6,591	7,416	21,083	1,357	193.01
193.02 WATSEKA CLINIC						193.02
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	162,805	29,159	33,512	106,618	28,796	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	25,821				13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY		34,346			16
17 SOCIAL SERVICE			11,551		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	9,515	6,825	2,172	160,858	30
44 SKILLED NURSING FACILITY	5,411	2,016	9,379	254,187	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	3,689	2,270		87,047	50
53 ANESTHESIOLOGY				1,726	53
54 RADIOLOGY-DIAGNOSTIC		5,396		177,596	54
60 LABORATORY		3,809		82,480	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		3,174		19,800	65
66 PHYSICAL THERAPY		1,667		42,095	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY				2,240	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				29,542	71
72 IMPL. DEV. CHARGED TO PATIENT				27,679	72
73 DRUGS CHARGED TO PATIENTS				29,502	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)		2,476		129,415	88
88.01 RHC II				9,339	88.01
88.02 RHC III				14,175	88.02
90 CLINIC				28,484	90
91 EMERGENCY	7,206	6,634		114,626	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES		79		24,181	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)	25,821	34,346	11,551	1,234,972	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				25,909	190
193.01 ASSISTED LIVING				82,893	193.01
193.02 WATSEKA CLINIC				17,601	193.02
194 FOUNDATION					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	25,821	34,346	11,551	1,361,375	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	160,858	30
44	SKILLED NURSING FACILITY	254,187	44
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	87,047	50
53	ANESTHESIOLOGY	1,726	53
54	RADIOLOGY-DIAGNOSTIC	177,596	54
60	LABORATORY	82,480	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	19,800	65
66	PHYSICAL THERAPY	42,095	66
67	OCCUPATIONAL THERAPY		67
68	SPEECH PATHOLOGY		68
69	ELECTROCARDIOLOGY	2,240	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	29,542	71
72	IMPL. DEV. CHARGED TO PATIENT	27,679	72
73	DRUGS CHARGED TO PATIENTS	29,502	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)	129,415	88
88.01	RHC II	9,339	88.01
88.02	RHC III	14,175	88.02
90	CLINIC	28,484	90
91	EMERGENCY	114,626	91
92	OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS			
95	AMBULANCE SERVICES	24,181	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)	1,234,972	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,909	190
193.01	ASSISTED LIVING	82,893	193.01
193.02	WATSEKA CLINIC	17,601	193.02
194	FOUNDATION		194
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	1,361,375	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
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			9,397,481			4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	27,648	27,648	959,423	-5,081,062	18,614,503	5
6 OPERATION OF PLANT	2,931	2,931	270,547		2,199,995	6
7 LAUNDRY & LINEN SERVICE	834	834			139,467	7
8 HOUSEKEEPING	666	666	267,392		373,503	8
9 DIETARY	2,602	2,602	397,762		806,150	9
10 CAFETERIA	423	423			11,110	10
11 MAINTENANCE OF PERSONNEL						11
12 NURSING ADMINISTRATION	689	689	108,082		151,637	12
13 CENTRAL SERVICES & SUPPLY						13
14 PHARMACY						14
15 MEDICAL RECORDS & LIBRARY	844	844	147,649		231,566	15
16 SOCIAL SERVICE	301	301	49,093		66,792	16
17 NONPHYSICIAN ANESTHETISTS						17
19 NURSING SCHOOL						19
20 I&R SRVCES-SALARY & FRINGES APPRVD						20
21 I&R SRVCES-OTHER PRGM COSTS APPRVD						21
22 PARAMED ED PRGM-(SPECIFY)						22
23 INPATIENT ROUTINE SERV COST CENTERS						23
30 ADULTS & PEDIATRICS	3,015	3,015	672,390		951,470	30
44 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS			1,392,117		2,003,866	44
50 OPERATING ROOM	1,565	1,565	364,579		853,862	50
53 ANESTHESIOLOGY					38,843	53
54 RADIOLOGY-DIAGNOSTIC	3,570	3,570	518,266		1,706,435	54
60 LABORATORY	1,323	1,323	372,391		989,119	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	490	490			63,353	65
66 PHYSICAL THERAPY	669	669	93,307		481,701	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY					57,410	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	724	724			221,115	71
72 IMPL. DEV. CHARGED TO PATIENT					709,526	72
73 DRUGS CHARGED TO PATIENTS	251	251	5,019		569,644	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)			1,704,705		2,542,611	88
88.01 RHC II			183,937		239,396	88.01
88.02 RHC III			231,240		363,361	88.02
90 CLINIC	717	717	46,250		190,667	90
91 EMERGENCY	1,637	1,637	725,450		1,283,494	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			424,220		617,837	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	8,933,819	-5,081,062	17,863,930	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	934	934			24,531	190
193.01 ASSISTED LIVING			169,881		274,852	193.01
193.02 WATSEKA CLINIC			293,781		451,190	193.02
194 FOUNDATION						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	94,070	1,267,305	1,242,058		5,081,062	202
203 UNIT COST MULT-WS B PT I	1.814867	24.449771	0.132169		0.272963	203
204 COST TO BE ALLOC PER B PT II					726,166	204
205 UNIT COST MULT-WS B PT II					0.039011	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	SQUARE	MEALS	MEALS	
	FEET	POUNDS OF	FEET	SERVED	SERVED	
	7	LAUNDRY	9	10	11	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7	74,891					7
8	834	253,810				8
9	666		74,345			9
10	2,602		2,602	127,105		10
11	423		423	19,244	283,669	11
12						12
13	689		689			13
14						14
15						15
16	844		844		9,149	16
17	301		301		2,465	17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	3,015	93,167	3,015	5,216	30,036	30
44	28,438	93,059	28,438	77,511	87,264	44
ANCILLARY SERVICE COST CENTERS						
50	1,565		1,565		25,283	50
53					2,080	53
54	3,570		3,570		24,580	54
60	1,323		1,323		18,367	60
62.30						62.30
65	490		490			65
66	669	10,216	669		11,183	66
67						67
68						68
69						69
71	724		724			71
72						72
73	251		251		274	73
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88	9,700		9,700		22,606	88
88.01						88.01
88.02						88.02
90	717		717		3,285	90
91	1,637		1,637		33,733	91
92						92
OTHER REIMBURSABLE COST CENTERS						
95						95
99.10						99.10
99.20						99.20
99.30						99.30
99.40						99.40
SPECIAL PURPOSE COST CENTERS						
118	58,458	196,442	56,958	101,971	270,305	118
NONREIMBURSABLE COST CENTERS						
190			934			190
193.01	16,433	57,368	16,453	25,134	13,364	193.01
193.02						193.02
194						194
200						200
201						201
202	2,800,512	208,723	500,360	1,141,012	205,560	202
203	37,394,507	0,822,359	6,730,244	8,976,925	0,724,647	203
204	162,805	29,159	33,512	106,618	28,796	204
205	2,173,893	0,114,885	0,450,763	0,838,818	0,101,513	205

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	62,351			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	13,065	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
69 ELECTROCARDIOLOGY				69
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)	62,351	10,820	117	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
193.01 ASSISTED LIVING				193.01
193.02 WATSEKA CLINIC				193.02
194 FOUNDATION				194
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	223,430	338,646	100,092	202
203 UNIT COST MULT-WS B PT I	3.583423	31.298152	855.487179	203
204 COST TO BE ALLOC PER B PT II	25,821	34,346	11,551	204
205 UNIT COST MULT-WS B PT II	0.414123	3.174307	98.726496	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,657,883		1,657,883		1,657,883	30
44 SKILLED NURSING FACILITY	4,789,201		4,789,201		4,789,201	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,228,607		1,228,607		1,228,607	50
53 ANESTHESIOLOGY	50,953		50,953		50,953	53
54 RADIOLOGY-DIAGNOSTIC	2,400,773		2,400,773		2,400,773	54
60 LABORATORY	1,368,357		1,368,357		1,368,357	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	133,565		133,565		133,565	65
66 PHYSICAL THERAPY	675,645		675,645		675,645	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	73,081		73,081		73,081	69
71 MEDICAL SUPPLIES CHRGED TO	313,418		313,418		313,418	71
72 IMPL. DEV. CHARGED TO PATIE	903,200		903,200		903,200	72
73 DRUGS CHARGED TO PATIENTS	736,410		736,410		736,410	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)	3,705,446		3,705,446		3,705,446	88
88.01 RHC II	304,742		304,742		304,742	88.01
88.02 RHC III	462,545		462,545		462,545	88.02
90 CLINIC	276,730		276,730		276,730	90
91 EMERGENCY	1,858,282		1,858,282		1,858,282	91
92 OBSERVATION BEDS	208,986		208,986		208,986	92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	787,266		787,266		787,266	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)	21,935,090		21,935,090		21,935,090	200
201 LESS OBSERVATION BEDS	208,986		208,986		208,986	201
202 TOTAL (SEE INSTRUCTIONS)	21,726,104		21,726,104		21,726,104	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	2,017,705		2,017,705			30
44 SKILLED NURSING FACILITY	4,007,074		4,007,074			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	692,676	4,396,083	5,088,759	0.241435	0.241435	0.241435 50
53 ANESTHESIOLOGY	138,306	1,641,507	1,779,813	0.028628	0.028628	0.028628 53
54 RADIOLOGY-DIAGNOSTIC	340,902	9,234,730	9,575,632	0.250717	0.250717	0.250717 54
60 LABORATORY	645,701	6,943,158	7,588,859	0.180311	0.180311	0.180311 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	259,213	364,419	623,632	0.214173	0.214173	0.214173 65
66 PHYSICAL THERAPY	682,411	1,098,290	1,780,701	0.379426	0.379426	0.379426 66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	67,751	1,433,702	1,501,453	0.048674	0.048674	0.048674 69
71 MEDICAL SUPPLIES CHRGD TO	278,625	976,514	1,255,139	0.249708	0.249708	0.249708 71
72 IMPL. DEV. CHARGED TO PATIE	426,450	199,449	625,899	1.443044	1.443044	1.443044 72
73 DRUGS CHARGED TO PATIENTS	1,006,949	1,262,366	2,269,315	0.324508	0.324508	0.324508 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)		2,850,281	2,850,281			88
88.01 RHC II		257,231	257,231			88.01
88.02 RHC III		5,184,816	5,184,816			88.02
90 CLINIC		146,187	146,187	1.892986	1.892986	1.892986 90
91 EMERGENCY	173,522	7,239,755	7,413,277	0.250669	0.250669	0.250669 91
92 OBSERVATION BEDS		479,342	479,342	0.435985	0.435985	0.435985 92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		1,084,522	1,084,522	0.725911	0.725911	0.725911 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)	10,737,285	44,792,352	55,529,637			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	10,737,285	44,792,352	55,529,637			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	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.241435		1,533,872			370,330	50
53 ANESTHESIOLOGY	0.028628						53
54 RADIOLOGY-DIAGNOSTIC	0.250717		2,432,112			609,772	54
60 LABORATORY	0.180311		2,316,520			417,694	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.214173		350,828			75,138	65
66 PHYSICAL THERAPY	0.379426		325,583			123,535	66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.048674		259,419			12,627	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.249708		434,060			108,388	71
72 IMPL. DEV. CHARGED TO PATIENT	1.443044		65,086			93,922	72
73 DRUGS CHARGED TO PATIENTS	0.324508		337,149	2,604		109,408	845 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	1.892986		101,202			191,574	90
91 EMERGENCY	0.250669		1,831,850			459,188	91
92 OBSERVATION BEDS	0.435985		257,070			112,079	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.725911						95
200 SUBTOTAL (SEE INSTRUCTIONS)			10,244,751	2,604		2,683,655	845 200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			10,244,751	2,604		2,683,655	845 202

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	0.241435						50
53 ANESTHESIOLOGY	0.028628						53
54 RADIOLOGY-DIAGNOSTIC	0.250717						54
60 LABORATORY	0.180311						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.214173						65
66 PHYSICAL THERAPY	0.379426						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.048674						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.249708						71
72 IMPL. DEV. CHARGED TO PATIENT	1.443044						72
73 DRUGS CHARGED TO PATIENTS	0.324508						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	1.892986						90
91 EMERGENCY	0.250669						91
92 OBSERVATION BEDS	0.435985						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.725911						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1			MEDICAL EDUCATION COST 4	COST (SUM OF COLS.1-4) 5	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
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD 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	5,088,759					50
53	ANESTHESIOLOGY	1,779,813					53
54	RADIOLOGY-DIAGNOSTIC	9,575,632		25,803			54
60	LABORATORY	7,588,859		74,948			60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	623,632		40,525			65
66	PHYSICAL THERAPY	1,780,701		409,660			66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	1,501,453					69
71	MEDICAL SUPPLIES CHRGED TO P	1,255,139		24,390			71
72	IMPL. DEV. CHARGED TO PATIEN	625,899					72
73	DRUGS CHARGED TO PATIENTS	2,269,315		344,255			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)	2,850,281					88
88.01	RHC II	257,231					88.01
88.02	RHC III	5,184,816					88.02
90	CLINIC	146,187					90
91	EMERGENCY	7,413,277		3,538			91
92	OBSERVATION BEDS	479,342					92
OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	48,420,336		923,119			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	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	0.241435						50
53 ANESTHESIOLOGY	0.028628						53
54 RADIOLOGY-DIAGNOSTIC	0.250717						54
60 LABORATORY	0.180311						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.214173						65
66 PHYSICAL THERAPY	0.379426						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.048674						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.249708						71
72 IMPL. DEV. CHARGED TO PATIENT	1.443044						72
73 DRUGS CHARGED TO PATIENTS	0.324508						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	1.892986						90
91 EMERGENCY	0.250669						91
92 OBSERVATION BEDS	0.435985						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.725911						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 DIEM (COL.3 ÷ COL.4)	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)					
	1	2	3					
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	160,858	36,250	124,608	1,100	113.28	90	10,195	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	254,187		254,187	26,632	9.54	16,488	157,296	44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	415,045		378,795	27,732		16,578	167,491	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	87,047	5,088,759	0.017106		50
53 ANESTHESIOLOGY	1,726	1,779,813	0.000970		53
54 RADIOLOGY-DIAGNOSTIC	177,596	9,575,632	0.018547		54
60 LABORATORY	82,480	7,588,859	0.010869		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	19,800	623,632	0.031749		65
66 PHYSICAL THERAPY	42,095	1,780,701	0.023640		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	2,240	1,501,453	0.001492		69
71 MEDICAL SUPPLIES CHRGED TO PA	29,542	1,255,139	0.023537		71
72 IMPL. DEV. CHARGED TO PATIENT	27,679	625,899	0.044223		72
73 DRUGS CHARGED TO PATIENTS	29,502	2,269,315	0.013000		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)	129,415	2,850,281	0.045404		88
88.01 RHC II	9,339	257,231	0.036306		88.01
88.02 RHC III	14,175	5,184,816	0.002734		88.02
90 CLINIC	28,484	146,187	0.194846		90
91 EMERGENCY	114,626	7,413,277	0.015462		91
92 OBSERVATION BEDS	26,176	479,342	0.054608		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-199)	821,922	48,420,336			200

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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	1,100		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)	27,732		16,578		200

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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			SCHOOL 2	MEDICAL EDUCATION COST 4	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
69 ELECTROCARDIOLOGY						69
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		O/P PGM CHARGES
	7		8		9		10		12
							INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)		O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
							11		13
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM		5,088,759						50
53	ANESTHESIOLOGY		1,779,813						53
54	RADIOLOGY-DIAGNOSTIC		9,575,632						54
60	LABORATORY		7,588,859						60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY		623,632						65
66	PHYSICAL THERAPY		1,780,701						66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY		1,501,453						69
71	MEDICAL SUPPLIES CHRGED TO P		1,255,139						71
72	IMPL. DEV. CHARGED TO PATIEN		625,899						72
73	DRUGS CHARGED TO PATIENTS		2,269,315						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)		2,850,281						88
88.01	RHC II		257,231						88.01
88.02	RHC III		5,184,816						88.02
90	CLINIC		146,187						90
91	EMERGENCY		7,413,277						91
92	OBSERVATION BEDS		479,342						92
OTHER REIMBURSABLE COST CENTERS									
95	AMBULANCE SERVICES		1,084,522						95
200	TOTAL (SUM OF LINES 50-199)		48,420,336						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	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	0.241435						50
53 ANESTHESIOLOGY	0.028628						53
54 RADIOLOGY-DIAGNOSTIC	0.250717						54
60 LABORATORY	0.180311						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.214173						65
66 PHYSICAL THERAPY	0.379426						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.048674						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.249708						71
72 IMPL. DEV. CHARGED TO PATIENT	1.443044						72
73 DRUGS CHARGED TO PATIENTS	0.324508						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	1.892986						90
91 EMERGENCY	0.250669						91
92 OBSERVATION BEDS	0.435985						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.725911						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)	1,420 1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,100 2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	921 4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	52 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)	268 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)	568 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)	52 10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	183 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)	1,657,883 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)	373,606 26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,284,277 27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,673,046 28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,673,046 30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.767628 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)	1,816.55 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)	1,284,277 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) 1,167.52 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 663,151 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) 663,151 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)					510,139	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,173,290	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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 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 INSTRUCTIONS) (TITLE XVIII ONLY) 60,711 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 213,656 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 274,367 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) 179 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,167.52 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 208,986 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) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	160,858	1,284,277	0.125252	208,986	26,176	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

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)	1,388	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 XVII 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)	4,789,201	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	4,789,201	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)	1.407287	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)	4,789,201	37

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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)	4,789,201	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	179.83	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	249,604	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)	249,604	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)	249,604	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	302,789	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	552,393	86

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1316) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] 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)	1,420	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,100	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	921	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	52	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)	268	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)	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 XVII 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)	1,657,883	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)	373,606	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,284,277	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,673,046	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,673,046	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.767628	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)	1,816.55	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)	1,284,277	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) 1,167.52 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 105,077 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) 105,077 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) 105,077 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 10,195 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 10,195 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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 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 INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (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) 179 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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		894,204			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.241435	91,356	22,057		50
53 ANESTHESIOLOGY	0.028628				53
54 RADIOLOGY-DIAGNOSTIC	0.250717	103,119	25,854		54
60 LABORATORY	0.180311	322,532	58,156		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.214173	137,207	29,386		65
66 PHYSICAL THERAPY	0.379426	29,212	11,084		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.048674				69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.249708	191,961	47,934		71
72 IMPL. DEV. CHARGED TO PATIENT	1.443044	157,444	227,199		72
73 DRUGS CHARGED TO PATIENTS	0.324508	270,616	87,817		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	1.892986				90
91 EMERGENCY	0.250669	2,602	652		91
92 OBSERVATION BEDS	0.435985				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,306,049	510,139		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,306,049			202

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

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	0.241435				50
53 ANESTHESIOLOGY	0.028628				53
54 RADIOLOGY-DIAGNOSTIC	0.250717	8,110		2,033	54
60 LABORATORY	0.180311	18,357		3,310	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.214173	11,044		2,365	65
66 PHYSICAL THERAPY	0.379426	99,540		37,768	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.048674				69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.249708	22,049		5,506	71
72 IMPL. DEV. CHARGED TO PATIENT	1.443044				72
73 DRUGS CHARGED TO PATIENTS	0.324508	56,944		18,479	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	1.892986				90
91 EMERGENCY	0.250669				91
92 OBSERVATION BEDS	0.435985				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		216,044		69,461	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		216,044			202

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	0.241435				50
53 ANESTHESIOLOGY	0.028628				53
54 RADIOLOGY-DIAGNOSTIC	0.250717	25,803	6,469		54
60 LABORATORY	0.180311	74,948	13,514		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.214173	40,525	8,679		65
66 PHYSICAL THERAPY	0.379426	409,660	155,436		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.048674				69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.249708	24,390	6,090		71
72 IMPL. DEV. CHARGED TO PATIENT	1.443044				72
73 DRUGS CHARGED TO PATIENTS	0.324508	344,255	111,714		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	1.892986				90
91 EMERGENCY	0.250669	3,538	887		91
92 OBSERVATION BEDS	0.435985				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		923,119	302,789		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		923,119			202

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
 PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
 02/25/2013 11:20

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1316) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF 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	0.241435			50
53 ANESTHESIOLOGY	0.028628			53
54 RADIOLOGY-DIAGNOSTIC	0.250717			54
60 LABORATORY	0.180311			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.214173			65
66 PHYSICAL THERAPY	0.379426			66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.048674			69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.249708			71
72 IMPL. DEV. CHARGED TO PATIENT	1.443044			72
73 DRUGS CHARGED TO PATIENTS	0.324508			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	1.892986			90
91 EMERGENCY	0.250669			91
92 OBSERVATION BEDS	0.435985			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)	2,684,500	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)	2,684,500	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)	2,711,345	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)	13,676	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,595,664	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	1,102,005	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)	1,102,005	30
31	PRIMARY PAYER PAYMENTS	227	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,101,778	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)	428,247	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	428,247	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	428,247	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	1,530,025	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)	1,530,025	40
41	INTERIM PAYMENTS	1,815,847	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-285,822	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		931,714		1,387,232	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.		33,204		301,417	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 09/13/2012	15,754			3.01
	.02 05/11/2012	56,436			3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08		09/13/2012	30,134	3.08
	.09		05/11/2012	97,064	3.09
	.50	NONE		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	72,190		127,198	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)		1,037,108		1,815,847	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	8,599			6.01
	TO PROVIDER .02			-285,822	6.02
	PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,045,707		1,530,025	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

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				253,674		1
2				NONE		2
3						
		.01		NONE		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	03/12/2010	7,392		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		-7,392		3.99
		SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				
4				246,282		4
TO BE COMPLETED BY CONTRACTOR						
5						
		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				100,985		6.01
		PROGRAM .01				6.01
		TO .02				6.02
7				347,267		7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	NPR DATE:	8

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		347,469		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)		347,469		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 .02 PROVIDER .03 PROVIDER .04 TO .05 PROGRAM .06	1		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		347,470		7
8 NAME OF CONTRACTOR: _____		CONTRACTOR NUMBER: _____	NPR DATE: _____	8

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H
PERIOD FROM 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1316) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

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	358	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	568	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	921	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	55,529,637	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	967,981	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 10/01/2011 TO 09/30/2012

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

VERSION: 2012.11
02/25/2013 11:20

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)	277,111	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)	70,156	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	235	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)	347,267	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	347,267	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	347,267	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		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)	347,267	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)	347,267	19
20 INTERIM PAYMENTS	246,282	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	100,985	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	1,173,290	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,173,290	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,185,023	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 AND 17)	1,185,023	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	172,392	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,012,631	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,012,631	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	33,076	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	33,076	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,045,707	28
29	OTHER ADJUSTMENTS (LOSS ON SALE OF ASSETS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,045,707	30
31	INTERIM PAYMENTS	1,037,108	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	8,599	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	427,275	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (SUM OF LINES 1-3)	427,275	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	MEDICAL AND OTHER SERVICES		5
6	DEDUCTIBLES		6
7	COINSURANCE	79,805	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)	347,470	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)	347,470	15
16	INTERIM PAYMENTS	347,469	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	1	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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1	105,077	1
2		2
3		3
4	105,077	4
5		5
6		6
7	105,077	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8		8
9		9
10		10
11		11
12		12
CUSTOMARY CHARGES		
13		13
14		14
15		15
16		16
17		17
18		18
19		19
20		20
21	105,077	21
PROSPECTIVE PAYMENT AMOUNT		
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29	105,077	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30		30
31	105,077	31
32		32
33		33
34		34
35		35
36	105,077	36
37		37
38	105,077	38
39		39
40	105,077	40
41		41
42	105,077	42
43		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	128,541			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	11,825,374			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-7,657,566			6
7 INVENTORY	255,780			7
8 PREPAID EXPENSES	314,228			8
9 OTHER CURRENT ASSETS				9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	4,866,357			11
FIXED ASSETS				
12 LAND	297,500			12
13 LAND IMPROVEMENTS	831,029			13
14 ACCUMULATED DEPRECIATION				14
15 BUILDINGS	13,503,787			15
16 ACCUMULATED DEPRECIATION	-4,435,454			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT	7,611,485			19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	8,339,001			23
24 ACCUMULATED DEPRECIATION	-3,935,854			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)	22,211,494			30
OTHER ASSETS				
31 INVESTMENTS	3,563,756			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS	563,832			33
34 OTHER ASSETS	380,354			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	4,507,942			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	31,585,793			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	4,317,197			37
38 SALARIES, WAGES & FEES PAYABLE				38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	1,343,839			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	3,049,800			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	8,710,836			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE	17,406,490			46
47 NOTES PAYABLE				47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	142,568			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	17,549,058			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	26,259,894			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	5,325,899			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)	5,325,899			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	31,585,793			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		6,335,241							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-1,013,798							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		5,321,443							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)		5,321,443							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)		5,321,443							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	4,973,336		4,973,336	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	336,406		336,406	6
7 SWING BED - NF				7
8 SKILLED NURSING FACILITY	5,427,534		5,427,534	8
9 NURSING FACILITY				9
10 OTHER LONG TERM CARE				10
TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	10,737,276		10,737,276	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)	10,737,276		10,737,276	18
18 ANCILLARY SERVICES				19
19 OUTPATIENT SERVICES		35,785,627	35,785,627	20
20 RHC		2,850,281	2,850,281	20.01
20.01 RHC II		389,567	389,567	20.02
20.02 RHC III		514,816	514,816	21
21 FQHC				22
22 HOME HEALTH AGENCY				23
23 AMBULANCE		1,056,630	1,056,630	25
25 ASC				26
26 HOSPICE				27
27 PROFESSIONAL FEES	201,150	727,816	928,966	28
		389,567	389,567	
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	10,938,426	41,714,304	52,652,730	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		26,676,178	29
30 ADD (SPECIFY)			30
31 BAD DEBTS			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			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)		26,676,178	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	52,652,730	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	28,090,006	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	24,562,724	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	26,676,178	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-2,113,454	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	13,604	6
7	INCOME FROM INVESTMENTS	32,853	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	6,445	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	6,924	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	10,026	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (TRUST INCOME)	132,315	24
24.01	OTHER (MISCELLANEOUS INCOME)		24.01
24.02	OTHER (UNREALIZED GAINS)		24.02
24.03	OTHER (GRANTS)	416,120	24.03
24.04	OTHER (CATERING)	21,344	24.04
24.05	OTHER (LOSS ON DISPOSAL)	-44,000	24.05
24.06	OTHER (COUNTY TERRACE)	504,025	24.06
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,099,656	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,013,798	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)	-1,013,798	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 HEMOPHILIC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
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
193.02 WATSEKA CLINIC					193.02
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-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	1,784,036	947,701	2,731,737	-216,235	2,515,502	-198,200	2,317,302	10
SUBTOTAL (SUM OF LINES 1-9)								
11								11
12								12
13								13
14								14
SUBTOTAL (SUM OF LINES 11-13)								
OTHER HEALTH CARE COSTS								
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22	1,784,036	947,701	2,731,737	-216,235	2,515,502	-198,200	2,317,302	22
SUBTOTAL (SUM OF LINES 15-20)								
TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)								
COSTS OTHER THAN RHC/FQHC SERVICES								
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	1,784,036	947,701	2,731,737	-216,235	2,515,502	-198,200	2,317,302	32
SUBTOTAL (SUM OF LINES 22, 28 AND 31)								

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	PHYSICIANS	3.00	22,851	4,200	12,600	1
2	PHYSICIAN ASSISTANTS	3.00		2,100	6,300	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	6.00	22,851		18,900	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	6.00	22,851			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)				2,317,302	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)				2,317,302	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)				1,388,144	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,388,144	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,388,144	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,388,144	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				3,705,446	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)			3,705,446	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)			82,980	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)			3,622,466	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)			22,851	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)				5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)			22,851	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)			158.53	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)	158.53	158.53	158.53	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,124	3,818		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	178,188	605,268		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)		783,456		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%)		583,459		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		583,459		16.05
17	PRIMARY PAYOR PAYMENTS		79		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		54,132		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		108,851		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		583,380		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		62,974		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		646,354		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		4,478		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		4,478		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		650,832		26
27	INTERIM PAYMENTS		493,830		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		157,002		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 I
 COMPONENT NO: 14-3448

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)	2,317,302	2,317,302	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)		43,049	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)		51,894	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	2,317,302	2,317,302	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,388,144	1,388,144	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.022394	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		31,086	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		82,980	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		477	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		173.96	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		362	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		62,974	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)		82,980	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)		62,974	16

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	183,937	37,048	220,985		220,985	-5,900	215,085	10
SUBTOTAL (SUM OF LINES 1-9)								
11	183,937	37,048	220,985		220,985	-5,900	215,085	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	183,937	37,048	220,985		220,985	-5,900	215,085	22
TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)								
COSTS OTHER THAN RHC/FQHC SERVICES								
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	183,937	37,048	220,985		220,985	-5,900	215,085	32
TOTAL FACILITY COSTS (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	0.60	2,060	1,260		2
3	NURSE PRACTITIONERS		2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	0.60	2,060	1,260	2,060	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.60	2,060		2,060	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)				215,085	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)				215,085	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)				89,657	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				89,657	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				89,657	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				89,657	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				304,742	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)	304,742	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	8,766	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	295,976	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	2,060	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,060	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	143.68	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)	143.68	143.68	143.68	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	173	404		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	24,857	58,047		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)		82,904		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%)		60,560		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		60,560		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		7,204		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		11,442		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		60,560		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		5,024		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		65,584		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		156		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		156		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		65,740		26
27	INTERIM PAYMENTS		66,609		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		-869		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)	215,085	215,085	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)		3,679	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)		6,187	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	215,085	215,085	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	89,657	89,657	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.028765	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		2,579	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		8,766	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		82	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		106.90	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		47	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		5,024	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)		8,766	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)		5,024	16

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10	253,412	124,659	378,071	-29,550	348,521	-15,723	332,798	10
SUBTOTAL (SUM OF LINES 1-9)								
11								11
12								12
13								13
14								14
SUBTOTAL (SUM OF LINES 11-13)								
OTHER HEALTH CARE COSTS								
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22	253,412	124,659	378,071	-29,550	348,521	-15,723	332,798	22
SUBTOTAL (SUM OF LINES 15-20)								
TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)								
COSTS OTHER THAN RHC/FQHC SERVICES								
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	253,412	124,659	378,071	-29,550	348,521	-15,723	332,798	32
SUBTOTAL (SUM OF LINES 22, 28 AND 31)								

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	PHYSICIANS	1.00	5,093	4,200	4,200	1
2	PHYSICIAN ASSISTANTS	0.20		2,100	420	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	1.20	5,093		4,620	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.20	5,093		5,093	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)				332,798	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)				332,798	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)				129,747	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				129,747	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				129,747	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				129,747	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				462,545	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)	462,545	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	10,559	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	451,986	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	5,093	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,093	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	88.75	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)	88.75	88.75	88.75	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	277	756		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	24,584	67,095		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)		91,679		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%)		61,094		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		61,094		16.05
17	PRIMARY PAYOR PAYMENTS		67		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		15,312		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		16,587		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		61,027		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		10,559		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		71,586		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		371		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		371		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		71,957		26
27	INTERIM PAYMENTS		43,484		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		28,473		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)	332,798	332,798	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)		5,393	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)		7,597	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	332,798	332,798	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	129,747	129,747	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.022828	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		2,962	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		10,559	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		21	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		502.81	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		21	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		10,559	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)		10,559	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)		10,559	16

