

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
  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.
- DATE: 02-26-2014 TIME: 13:47
- CONTRACTOR USE ONLY
5.  COST REPORT STATUS
  6. DATE RECEIVED: \_\_\_\_\_
  7. CONTRACTOR NO: \_\_\_\_\_
  8.  INITIAL REPORT FOR THIS PROVIDER CCN
  9.  FINAL REPORT FOR THIS PROVIDER CCN
  10. NPR DATE: \_\_\_\_\_
  11. CONTRACTOR'S VENDOR CODE: \_\_\_\_\_
  12.  IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED - 0-9.
- 1 - AS SUBMITTED
  - 2 - SETTLED WITHOUT AUDIT
  - 3 - SETTLED WITH AUDIT
  - 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 10/01/2012 AND ENDING 09/30/2013, 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			TITLE XIX 5	
		PART A 2	PART B 3	HIT 4		
1 HOSPITAL		308,272	137,245	-20,530	44,145	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		137,703				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			310,644			10
10.01 HEALTH CLINIC - RHC II			25,169			10.01
10.02 HEALTH CLINIC - RHC III			82,736			10.02
10.03 HEALTH CLINIC - RHC IV			179,472			10.03
10.04 HEALTH CLINIC - RHC V			63,888			10.04
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		445,975	799,154	-20,530	44,145	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 (CONT)

	V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL	1	2	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' FOR NO.	N	N	N	48
TEACHING HOSPITALS	1	2	3	
56 IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57 IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58 IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	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 HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. )(SEE INSTRUCTIONS)	Y/N N	IME	DIRECT GME	61
61.01 ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02 ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY FTEs, AND PRIMARY CARE FTEs ADDED UNDER SECTION 5503). (SEE INSTRUCTIONS)				61.02
61.03 ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04 ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05 ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06 ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS)				
ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
	PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED IME FTE COUNT 3	UNWEIGHTED DIRECT GME FTE COUNT 4 61.10
OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS)				
ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.				
				61.20
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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS) N 63

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010. UNWEIGHTED FTE NONPROVIDER SITE UNWEIGHTED FTE IN HOSPITAL RATIO (COL.1/(COL.1+COL.2)) 64

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)

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	PROGRAM CODE	UNWEIGHTED FTE NONPROVIDER SITE	UNWEIGHTED FTE IN HOSPITAL	RATIO (COL.3+COL.4)
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010 UNWEIGHTED FTE NONPROVIDER SITE UNWEIGHTED FTE IN HOSPITAL RATIO (COL.1/(COL.1+COL.2)) 66

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)

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTE NONPROVIDER SITE	UNWEIGHTED FTE IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	4	5

INPATIENT PSYCHIATRIC FACILITY PPS

70 IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? 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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

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. V XIX  
 1 2  
 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  
 Y 105  
 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

PHY- OCCUP- RESPI-  
 SICAL ATIONAL SPEECH RATORY

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. N N N N 109

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: 118.01  
 PREMIUMS: 167,771 PAID LOSSES: SELF INSURANCE:  
 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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TRANSPLANT CENTER INFORMATION

		1	2
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

		1	2
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.	Y	14H077 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: CARLE HEALTH SYSTEM	CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES	CONTRACTOR'S NUMBER: 00450	141
142	STREET: 611 WEST PARK STREET	P.O. BOX:		142
143	CITY: URBANA	STATE: IL	ZIP CODE: 61801	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	TITLE	
	PART A	PART B	V	
	1	2	3	
			XIX	
			4	
155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161
161.10	CORF			161.10

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.		Y	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.		484,229	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
170	IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)		10/01/2012 09/30/2012	170

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

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
		1	2	
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		1
		Y/N	DATE	V/I
		1	2	3
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	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)	Y		3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
		1	2	3
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		4
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	
		1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		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
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y	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.		N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	14
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N	15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
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	01/17/2014	Y	01/17/2014
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 RELIEVED 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. N 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. N 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. N 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. Y 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. Y 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. Y 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. Y 35

HOME OFFICE COSTS

- |   | Y/N | DATE       |    |
|---|-----|------------|----|
|   | 1   | 2          |    |
| 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?   | Y   |            | 36 |
| 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  | Y   |            | 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. | Y   | 12/31/2013 | 38 |
| 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.   | N   |            | 39 |
| 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  | N   |            | 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

LINE	AMOUNT	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	9,800,345	-237,045	407,247.00	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				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		397,188		31,974.00	10
	OTHER WAGES & RELATED COSTS					
11	CONTRACT LABOR (SEE INSTRUCTIONS)	1			1.00	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					16
	WAGE-RELATED COSTS					
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)					25
	OVERHEAD COSTS - DIRECT SALARIES					
26	EMPLOYEE BENEFITS DEPARTMENT		62,249		2,435.00	26
27	ADMINISTRATIVE & GENERAL		975,322	-46,629	53,336.00	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		220,338		12,727.00	30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING		150,223		13,634.00	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		182,267		14,132.00	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION		327,233		6,905.00	38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		98,337		6,191.00	41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	9,800,345	-237,045	9,563,300	407,247.00	23.48	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	397,188		397,188	31,974.00	12.42	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	9,403,157	-237,045	9,166,112	375,273.00	24.43	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1		1	1.00	1.00	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	1,434,005		1,434,005		15.64	5
6	TOTAL (SUM OF LINES 3 THRU 5)	10,837,163	-237,045	10,600,118	375,274.00	28.25	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	2,015,969	-46,629	1,969,340	109,360.00	18.01	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
RETIREMENT COST			
1	401K EMPLOYER CONTRIBUTIONS	90,036	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)	1,411,253	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	6,561	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	29,895	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	29,149	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	673,975	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	78,191	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	45,983	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,365,043	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25
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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 OLTC		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
14.03	HOSPITAL-BASED HEALTH CLINIC - RHC IV		14.03
14.04	HOSPITAL-BASED HEALTH CLINIC - RHC V		14.04
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			10
11	RLX			11
12	RUC			12
13	RUB	25		25
14	RUA			14
15	RVC			15
16	RVB	6		6
17	RVA	82		82
18	RHC	8		8
19	RHB			19
20	RHA	52		52
21	RMC			21
22	RMB			22
23	RMA	9		9
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1			28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1			36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1			48
49	CC2			49
50	CC1			50
51	CB2			51
52	CB1	4		4
53	CA2			53
54	CA1			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			66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

GROUP		SNF	SWING BED	TOTAL
1		DAYS	SNF DAYS	(COLS.
		2	3	2 + 3)
				4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2	3		73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL	189		189 200

SNF SERVICES		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)

		ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?		
		EXPENSES	PERCENTAGE	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)	28,362		207

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

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 801 EAST ORANGE STREET 1  
 2 CITY: HOOPESTON STATE: IL ZIP CODE: 60452 COUNTY: VERMILLION 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  
 N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC	0900		0800	2000	0800	2000	0800	2000	0800	2000	0800	2000	0900	1700	11

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

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2  
 N 12  
 13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 13

ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO 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  
 N

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

RHC II  
 COMPONENT NO: 14-3485

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:

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

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.  
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. 1 2  
N 10

FACILITY HOURS OF OPERATIONS(1)

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

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

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

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR Y/N V XVIII XIX TOTAL  
 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF N 15  
 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)

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. 1 2  
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

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

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

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED 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  
 N

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

RHC IV  
 COMPONENT NO: 14-8521

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 845 S. 4TH ST. 1  
 2 CITY: WATSEKA STATE: IL ZIP CODE: 60970 COUNTY: IROQUOIS 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

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 N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC	0800	1200	0800	2000	0800	2000	0800	2000	0800	2000	0800	2000	0800	1200	11

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

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

14 PROVIDER NAME: CCN NUMBER: 14

	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

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11  
02/26/2014 13:47

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

RHC V  
COMPONENT NO: 14-8526

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 322 CHICAGO STR 1  
2 CITY: MILFORD STATE: IL. ZIP CODE: 60953 COUNTY: 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

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

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			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  
N N

13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? 12 13  
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE  
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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  
N

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)			0.526090	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)			5,911,128	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.			1,966,100	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)			1,966,100	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)	509,245		509,245	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	509,245		509,245	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			237,235	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,373,140	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			722,395	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,231,640	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			3,197,740	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				1,596,229	1
2	00200					2
3	00300		633,603	633,603		3
4	00400	62,249	34,960	97,209	1	4
5	00500	975,322	6,596,341	7,571,663	-891,689	5
6	00600					6
7	00700	220,338	656,024	876,362	17,175	7
8	00800					8
9	00900	150,223	119,378	269,601	-1,020	9
10	01000	182,267	149,284	331,551	-2,334	10
11	01100					11
12	01200					12
13	01300	327,233	62,722	389,955		13
14	01400		165,292	165,292	-85,507	14
15	01500					15
16	01600	98,337	45,150	143,487	-11,159	16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	739,288	371,898	1,111,186	183,068	30
31	03100					31
44	04400		119,219	119,219	-71,694	44
ANCILLARY SERVICE COST CENTERS						
50	05000	439,001	1,618,851	2,057,852	-931,525	50
53	05300	241,663	124,184	365,847	-38,054	53
54	05400	622,178	1,277,872	1,900,050	-81,915	54
60	06000	411,544	631,216	1,042,760	-89,582	60
62.30	06250					62.30
65	06500					65
66	06600	249,309	197,379	446,688	-1,739	66
71	07100				85,507	71
72	07200				788,403	72
73	07300	21,170	456,475	477,645	-3,392	73
74	07400					74
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	1,854,628	1,256,580	3,111,208	-86,448	88
88.01	08801	196,958	80,668	277,626		88.01
88.02	08802	309,989	207,287	517,276	-29,966	88.02
88.03	08803	1,271,861	427,489	1,699,350	-41,622	88.03
88.04	08804	206,339	215,596	421,935	-32,901	88.04
90	09000					90
91	09100	823,260	1,652,793	2,476,053	-269,836	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
94	09400					94
95	09500	397,188	253,287	650,475		95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
118		9,800,345	17,353,548	27,153,893		118
NONREIMBURSABLE COST CENTERS						
190	19000					190
193.01	19301		350	350		193.01
193.02	19302					193.02
194	07950					194
200		9,800,345	17,353,898	27,154,243		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	1,596,229	-144,043	1,452,186	1
2	00200	CAP REL COSTS-MVBLE EQUIP	633,603		633,603	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	97,210	-19,908	77,302	4
5	00500	ADMINISTRATIVE & GENERAL	6,679,974	1,262,600	7,942,574	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	893,537	-120,004	773,533	7
8	00800	LAUNDRY & LINEN SERVICE				8
9	00900	HOUSEKEEPING	268,581		268,581	9
10	01000	DIETARY	329,217	-136,556	192,661	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	389,955		389,955	13
14	01400	CENTRAL SERVICES & SUPPLY	79,785		79,785	14
15	01500	PHARMACY				15
16	01600	MEDICAL RECORDS & LIBRARY	132,328	-20,383	111,945	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,294,254		1,294,254	30
31	03100	INTENSIVE CARE UNIT				31
44	04400	SKILLED NURSING FACILITY	47,525		47,525	44
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	1,126,327		1,126,327	50
53	05300	ANESTHESIOLOGY	327,793	-237,045	90,748	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,818,135		1,818,135	54
60	06000	LABORATORY	953,178		953,178	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY				65
66	06600	PHYSICAL THERAPY	444,949		444,949	66
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,507		85,507	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	788,403		788,403	72
73	07300	DRUGS CHARGED TO PATIENTS	474,253		474,253	73
74	07400	RENAL DIALYSIS				74
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC	3,024,760	-1,058	3,023,702	88
88.01	08801	RHC II	277,626		277,626	88.01
88.02	08802	RHC III	487,310		487,310	88.02
88.03	08803	RHC IV	1,657,728		1,657,728	88.03
88.04	08804	RHC V	389,034		389,034	88.04
90	09000	CLINIC				90
91	09100	EMERGENCY	2,206,217	-657,476	1,548,741	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS						
94	09400	HOME PROGRAM DIALYSIS				94
95	09500	AMBULANCE SERVICES	650,475		650,475	95
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	27,153,893	-73,873	27,080,020	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
193.01	19301	ASSISTED LIVING	350		350	193.01
193.02	19302	WATSEKA CLINIC				193.02
194	07950	FOUNDATION				194
200		TOTAL (SUM OF LINES 118-199)	27,154,243	-73,873	27,080,370	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER
	1	2	3	4	5
1 INTEREST EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		635,919 1
2					2
500 TOTAL RECLASSIFICATIONS					635,919 500
CODE LETTER - A					
1 SURGERY SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71		85,507 1
2		IMPL. DEV. CHARGED TO PATIENT	72		788,403 2
500 TOTAL RECLASSIFICATIONS					873,910 500
CODE LETTER - B					
1 CAPITAL INSURANCE	C	CAP REL COSTS-BLDG & FIXT	1		17,294 1
500 TOTAL RECLASSIFICATIONS					17,294 500
CODE LETTER - C					
1 UTILITY EXPENSE	D	OPERATION OF PLANT	7		32,912 1
2					2
500 TOTAL RECLASSIFICATIONS					32,912 500
CODE LETTER - D					
1 BENEFITS	E	EMPLOYEE BENEFITS DEPARTMENT	4		1 1
500 TOTAL RECLASSIFICATIONS					1 500
CODE LETTER - E					
1 INSURANCE EXPENSE	F	ADMINISTRATIVE & GENERAL	5		91,425 1
2					2
3					3
4					4
500 TOTAL RECLASSIFICATIONS					91,425 500
CODE LETTER - F					
1 CRNA SALARIES	G	ANESTHESIOLOGY	53		237,045 1
500 TOTAL RECLASSIFICATIONS					237,045 500
CODE LETTER - G					
1 DEPRECIATION EXPENSE	H	CAP REL COSTS-BLDG & FIXT	1		943,016 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
500 TOTAL RECLASSIFICATIONS					943,016 500
CODE LETTER - H					
1 RECRUTINING EXPENSE	I	ADMINISTRATIVE & GENERAL	5		201,046 1
2					2
3					3
4					4
500 TOTAL RECLASSIFICATIONS					201,046 500
CODE LETTER - I					
1 RHC SPECIALTY PHYSICIAN	J	RURAL HEALTH CLINIC	88	46,629	5,543 1
500 TOTAL RECLASSIFICATIONS				46,629	5,543 500
CODE LETTER - J					
1 HOSPITALIST CALL COVERAGE	K	ADULTS & PEDIATRICS	30		189,360 1
500 TOTAL RECLASSIFICATIONS					189,360 500
CODE LETTER - K					
GRAND TOTAL (INCREASES)				46,629	3,227,471

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		578,575	11 1
2		SKILLED NURSING FACILITY	44		57,344	2
500 TOTAL RECLASSIFICATIONS					635,919	500
CODE LETTER - A						
1 SURGERY SUPPLIES	B	CENTRAL SERVICES & SUPPLY	14		85,507	1
2		OPERATING ROOM	50		788,403	2
500 TOTAL RECLASSIFICATIONS					873,910	500
CODE LETTER - B						
1 CAPITAL INSURANCE	C	ADMINISTRATIVE & GENERAL	5		17,294	11 1
500 TOTAL RECLASSIFICATIONS					17,294	500
CODE LETTER - C						
1 UTILITY EXPENSE	D	ADMINISTRATIVE & GENERAL	5		18,562	1
2		SKILLED NURSING FACILITY	44		14,350	2
500 TOTAL RECLASSIFICATIONS					32,912	500
CODE LETTER - D						
1 BENEFITS	E	ADMINISTRATIVE & GENERAL	5		1	1
500 TOTAL RECLASSIFICATIONS					1	500
CODE LETTER - E						
1 INSURANCE EXPENSE	F	RURAL HEALTH CLINIC	88		17,552	1
2		RHC III	88.02		14,966	2
3		RHC IV	88.03		41,622	3
4		EMERGENCY	91		17,285	4
500 TOTAL RECLASSIFICATIONS					91,425	500
CODE LETTER - F						
1 CRNA SALARIES	G	ANESTHESIOLOGY	53	237,045		1
500 TOTAL RECLASSIFICATIONS				237,045		500
CODE LETTER - G						
1 DEPRECIATION EXPENSE	H	ADMINISTRATIVE & GENERAL	5		517,556	9 1
2		OPERATION OF PLANT	7		15,737	2
3		HOUSEKEEPING	9		1,020	3
4		DIETARY	10		2,334	4
5		MEDICAL RECORDS & LIBRARY	16		11,159	5
6		ADULTS & PEDIATRICS	30		6,292	6
7		OPERATING ROOM	50		143,122	7
8		ANESTHESIOLOGY	53		5,977	8
9		RADIOLOGY-DIAGNOSTIC	54		81,915	9
10		LABORATORY	60		89,582	10
11		PHYSICAL THERAPY	66		1,739	11
12		DRUGS CHARGED TO PATIENTS	73		3,392	12
13		EMERGENCY	91		63,191	13
500 TOTAL RECLASSIFICATIONS					943,016	500
CODE LETTER - H						
1 RECRUTINING EXPENSE	I	ANESTHESIOLOGY	53		32,077	1
2		RURAL HEALTH CLINIC	88		121,068	2
3		RHC III	88.02		15,000	3
4		RHC V	88.04		32,901	4
500 TOTAL RECLASSIFICATIONS					201,046	500
CODE LETTER - I						
1 RHC SPECIALTY PHYSICIAN	J	ADMINISTRATIVE & GENERAL	5	46,629	5,543	1
500 TOTAL RECLASSIFICATIONS				46,629	5,543	500
CODE LETTER - J						
1 HOSPITALIST CALL COVERAGE	K	EMERGENCY	91		189,360	1
500 TOTAL RECLASSIFICATIONS					189,360	500
CODE LETTER - K						
GRAND TOTAL (DECREASES)				283,674	2,990,426	

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	758,510					758,510		2
3 BUILDINGS AND FIXTURES	13,171,844					13,171,844		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	3,212,615					3,212,615		5
6 MOVABLE EQUIPMENT	5,198,906					5,198,906		6
7 HIT DESIGNATED ASSETS		505,743		505,743		505,743		7
8 SUBTOTAL (SUM OF LINES 1-7)	22,733,845	505,743		505,743		23,239,588		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	22,733,845	505,743		505,743		23,239,588		10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT							1
2 CAP REL COSTS-MVBLE EQUIP	633,603						633,603 2
3 TOTAL (SUM OF LINES 1-2)	633,603						633,603 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	806,747		645,439				1,452,186 1
2 CAP REL COSTS-MVBLE EQUIP	633,603						633,603 2
3 TOTAL	1,440,350		645,439				2,085,789 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

LINE NO.	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
				COST CENTER	LINE NO.	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-7,774	CAP REL COSTS-BLDG & FIXT	1	11 1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9	PARKING LOT (CHAPTER 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-657,476			10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	1,802,672			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-19,077	DIETARY	10	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-20,383	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33	CATERING	B	-23,402	DIETARY	10	33
34	OTHER INCOME	B	-579	ADMINISTRATIVE & GENERAL	5	34
35	LOBBYING EXPENSE	A	-1	ADMINISTRATIVE & GENERAL	5	35
36	CLINIC MEDICAL RECORD REVENUE	B	-1,058	RURAL HEALTH CLINIC	88	36
37	MARKETING SALARIES	A	-38,438	ADMINISTRATIVE & GENERAL	5	37
38	MARKETING EXPENSE	A	-68,985	ADMINISTRATIVE & GENERAL	5	38
39	MARKETING BENEFITS	A	-11,842	ADMINISTRATIVE & GENERAL	5	39
40	MISCELLANEOUS REVENUE	B	-7,044	ADMINISTRATIVE & GENERAL	5	40
41	PROVIDER TAX	A	-413,183	ADMINISTRATIVE & GENERAL	5	41
42	COUNTRY TERRACE DIETARY	B	-94,077	DIETARY	10	42
43	CRNA SALARIES	A	-237,045	ANESTHESIOLOGY	53	43
43.01	CRNA BENEFITS	A	-19,908	EMPLOYEE BENEFITS DEPARTMENT	4	43.01
44	COUNTRY TERRACE RENT	B	-120,004	OPERATION OF PLANT	7	44
45						45
45.02	POB LAPSING SCHEDULE	A	8,160	CAP REL COSTS-BLDG & FIXT	1	9 45.02
46	EHR ASSET DEPRECIATION	A	-144,429	CAP REL COSTS-BLDG & FIXT	1	9 46
47						47
48						48
49						49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-73,873			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	5	ADMINISTRATIVE & GENERAL				
2		MANAGEMENT FEES	5,139,912	3,337,240	1,802,672	1
3						2
4						3
5		TOTALS (SUM OF LINES 1-4)	5,139,912	3,337,240	1,802,672	4
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				5

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	B		CARLE HEALTH SYSTEM	100.00	HOME OFFICE
7					
8					
9					
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-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	1	2	3	4	5	6	7	8	9
3	30	ADULTS & PEDIATRICS	HOSPITALIST CAL	315,255		315,255			3
4	91	EMERGENCY	AGGREGATE	1,011,501	657,476	354,025			4
200		TOTAL		1,326,756	657,476	669,280			200



PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11  
 02/26/2014 13:47

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 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9		415.00	1,798.00			9
10		71.23	53.43			10
11	35.62	35.62	26.72			11
12						12
12.01						12.01
13						13
13.01						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 10/01/2012 TO 09/30/2013

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

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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 10/01/2012 TO 09/30/2013

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

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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

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 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9		2,095.00	1,696.00			9
10		71.23	53.43	35.62		10
11	35.62	35.62	26.72			11
12						12
12.01						12.01
13						13
13.01						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

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 10/01/2012 TO 09/30/2013

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

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02/26/2014 13:47

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 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11  
02/26/2014 13:47

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 10/01/2012 TO 09/30/2013

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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 10/01/2012 TO 09/30/2013

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

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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 DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,452,186	1,452,186				1
2 CAP REL COSTS-MVBLE EQUIP	633,603		633,603			2
4 EMPLOYEE BENEFITS DEPARTMENT	77,302			77,302		4
5 ADMINISTRATIVE & GENERAL	7,942,574	774,605	337,968	7,556	9,062,703	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	773,533	82,117	35,828	1,793	893,271	7
8 LAUNDRY & LINEN SERVICE		23,366	10,195		33,561	8
9 HOUSEKEEPING	268,581	18,659	8,141	1,222	296,603	9
10 DIETARY	192,661	72,899	31,807	1,483	298,850	10
11 CAFETERIA		11,851	5,171		17,022	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	389,955	19,303	8,422	2,662	420,342	13
14 CENTRAL SERVICES & SUPPLY	79,785				79,785	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	111,945	23,646	10,317	800	146,708	16
17 SOCIAL SERVICE		8,433	3,679		12,112	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,294,254	84,470	36,855	6,015	1,421,594	30
31 INTENSIVE CARE UNIT						31
44 SKILLED NURSING FACILITY	47,525				47,525	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,126,327	43,846	19,130	3,572	1,192,875	50
53 ANESTHESIOLOGY	90,748			38	90,786	53
54 RADIOLOGY-DIAGNOSTIC	1,818,135	100,019	43,639	5,062	1,966,855	54
60 LABORATORY	953,178	37,066	16,172	3,348	1,009,764	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		13,728	5,990		19,718	65
66 PHYSICAL THERAPY	444,949	18,743	8,178	2,028	473,898	66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	85,507	20,284	8,850		114,641	71
72 IMPL. DEV. CHARGED TO PATIENTS	788,403				788,403	72
73 DRUGS CHARGED TO PATIENTS	474,253	7,032	3,068	172	484,525	73
74 RENAL DIALYSIS						74
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	3,023,702			15,470	3,039,172	88
88.01 RHC II	277,626			1,602	279,228	88.01
88.02 RHC III	487,310			2,522	489,832	88.02
88.03 RHC IV	1,657,728			10,348	1,668,076	88.03
88.04 RHC V	389,034			1,679	390,713	88.04
90 CLINIC		20,088	8,765		28,853	90
91 EMERGENCY	1,548,741	45,863	20,011	6,698	1,621,313	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	650,475			3,232	653,707	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)	27,080,020	1,426,018	622,186	77,302	27,042,435	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		26,168	11,417		37,585	190
193.01 ASSISTED LIVING	350				350	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)	27,080,370	1,452,186	633,603	77,302	27,080,370	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL	9,062,703					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	449,306	1,342,577				7
8 LAUNDRY & LINEN SERVICE	16,881	34,571	85,013			8
9 HOUSEKEEPING	149,188	27,607		473,398		9
10 DIETARY	150,319	107,857		39,313	596,339	10
11 CAFETERIA	8,562	17,534		6,391		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	211,428	28,560		10,410		13
14 CENTRAL SERVICES & SUPPLY	40,131					14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	73,793	34,985		12,752		16
17 SOCIAL SERVICE	6,092	12,477		4,548		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	715,048	124,977	76,612	45,552	37,600	30
31 INTENSIVE CARE UNIT		98,199		35,792		31
44 SKILLED NURSING FACILITY	23,905				558,739	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	600,004	64,872		23,645		50
53 ANESTHESIOLOGY	45,664					53
54 RADIOLOGY-DIAGNOSTIC	989,308	147,982		53,938		54
60 LABORATORY	507,901	54,841		19,989		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	9,918	20,311				65
66 PHYSICAL THERAPY	238,366	27,731	8,401	10,108		66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	57,663	30,011		10,939		71
72 IMPL. DEV. CHARGED TO PATIENTS	396,559					72
73 DRUGS CHARGED TO PATIENTS	243,711	10,404		3,792		73
74 RENAL DIALYSIS						74
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	1,528,669	402,081		146,552		88
88.01 RHC II	140,449					88.01
88.02 RHC III	246,381					88.02
88.03 RHC IV	839,026					88.03
88.04 RHC V	196,525					88.04
90 CLINIC	14,513	29,721		10,833		90
91 EMERGENCY	815,504	67,856		24,733		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	328,808					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)	9,043,622	1,342,577	85,013	459,287	596,339	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,905			14,111		190
193.01 ASSISTED LIVING	176					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)	9,062,703	1,342,577	85,013	473,398	596,339	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						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	49,509					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		670,740				13
14 CENTRAL SERVICES & SUPPLY			119,916			14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,663			269,901		16
17 SOCIAL SERVICE					35,229	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,228	255,963		62,815	25,835	30
31 INTENSIVE CARE UNIT						31
44 SKILLED NURSING FACILITY				1,548	9,394	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,578	126,703		20,890		50
53 ANESTHESIOLOGY	501					53
54 RADIOLOGY-DIAGNOSTIC	6,063			49,668		54
60 LABORATORY	5,059			35,060		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY	2,915			15,339		66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS			19,408			71
72 IMPL. DEV. CHARGED TO PATIENTS			100,508			72
73 DRUGS CHARGED TO PATIENTS	98					73
74 RENAL DIALYSIS						74
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	14,269			22,789		88
88.01 RHC II						88.01
88.02 RHC III						88.02
88.03 RHC IV						88.03
88.04 RHC V						88.04
90 CLINIC						90
91 EMERGENCY	8,135	288,074		61,062		91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES				730		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)	49,509	670,740	119,916	269,901	35,229	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 TOTAL (SUM OF LINES 118-201)	49,509	670,740	119,916	269,901	35,229	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	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 DEPARTMENT				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 SERVICES-SALARY & FRINGES APPRVD				21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	2,773,224		2,773,224	30
31 INTENSIVE CARE UNIT	133,991		133,991	31
44 SKILLED NURSING FACILITY	641,111		641,111	44
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	2,032,567		2,032,567	50
53 ANESTHESIOLOGY	136,951		136,951	53
54 RADIOLOGY-DIAGNOSTIC	3,213,814		3,213,814	54
60 LABORATORY	1,632,614		1,632,614	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	49,947		49,947	65
66 PHYSICAL THERAPY	776,758		776,758	66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	232,662		232,662	71
72 IMPL. DEV. CHARGED TO PATIENTS	1,285,470		1,285,470	72
73 DRUGS CHARGED TO PATIENTS	742,530		742,530	73
74 RENAL DIALYSIS				74
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	5,153,532		5,153,532	88
88.01 RHC II	419,677		419,677	88.01
88.02 RHC III	736,213		736,213	88.02
88.03 RHC IV	2,507,102		2,507,102	88.03
88.04 RHC V	587,238		587,238	88.04
90 CLINIC	83,920		83,920	90
91 EMERGENCY	2,886,677		2,886,677	91
92 OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
95 AMBULANCE SERVICES	983,245		983,245	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)	27,009,243		27,009,243	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,601		70,601	190
193.01 ASSISTED LIVING	526		526	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)	27,080,370		27,080,370	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 DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL		774,605	337,968	1,112,573	1,112,573	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		82,117	35,828	117,945	55,159	7
8 LAUNDRY & LINEN SERVICE		23,366	10,195	33,561	2,072	8
9 HOUSEKEEPING		18,659	8,141	26,800	18,315	9
10 DIETARY		72,899	31,807	104,706	18,454	10
11 CAFETERIA		11,851	5,171	17,022	1,051	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		19,303	8,422	27,725	25,956	13
14 CENTRAL SERVICES & SUPPLY					4,927	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY		23,646	10,317	33,963	9,059	16
17 SOCIAL SERVICE		8,433	3,679	12,112	748	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		84,470	36,855	121,325	87,782	30
31 INTENSIVE CARE UNIT						31
44 SKILLED NURSING FACILITY					2,935	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		43,846	19,130	62,976	73,659	50
53 ANESTHESIOLOGY					5,606	53
54 RADIOLOGY-DIAGNOSTIC		100,019	43,639	143,658	121,451	54
60 LABORATORY		37,066	16,172	53,238	62,352	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		13,728	5,990	19,718	1,218	65
66 PHYSICAL THERAPY		18,743	8,178	26,921	29,263	66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		20,284	8,850	29,134	7,079	71
72 IMPL. DEV. CHARGED TO PATIENTS					48,683	72
73 DRUGS CHARGED TO PATIENTS		7,032	3,068	10,100	29,919	73
74 RENAL DIALYSIS						74
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					187,663	88
88.01 RHC II					17,242	88.01
88.02 RHC III					30,247	88.02
88.03 RHC IV					103,002	88.03
88.04 RHC V					24,126	88.04
90 CLINIC		20,088	8,765	28,853	1,782	90
91 EMERGENCY		45,863	20,011	65,874	100,114	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES					40,366	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)		1,426,018	622,186	2,048,204	1,110,230	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		26,168	11,417	37,585	2,321	190
193.01 ASSISTED LIVING					22	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)		1,452,186	633,603	2,085,789	1,112,573	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	173,104					7
8 LAUNDRY & LINEN SERVICE	4,457	40,090				8
9 HOUSEKEEPING	3,559		48,674			9
10 DIETARY	13,906		4,042	141,108		10
11 CAFETERIA	2,261		657		20,991	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,682		1,070			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	4,511		1,311		705	16
17 SOCIAL SERVICE	1,609		468			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	16,114	36,128	4,684	8,897	3,064	30
31 INTENSIVE CARE UNIT	12,661		3,680			31
44 SKILLED NURSING FACILITY				132,211		44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8,364		2,431		1,517	50
53 ANESTHESIOLOGY					212	53
54 RADIOLOGY-DIAGNOSTIC	19,080		5,546		2,570	54
60 LABORATORY	7,071		2,055		2,145	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,619					65
66 PHYSICAL THERAPY	3,575	3,962	1,039		1,236	66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,869		1,125			71
72 IMPL. DEV. CHARGED TO PATIENTS						72
73 DRUGS CHARGED TO PATIENTS	1,341		390		42	73
74 RENAL DIALYSIS						74
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	51,844		15,068		6,051	88
88.01 RHC II						88.01
88.02 RHC III						88.02
88.03 RHC IV						88.03
88.04 RHC V						88.04
90 CLINIC	3,832		1,114			90
91 EMERGENCY	8,749		2,543		3,449	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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)	173,104	40,090	47,223	141,108	20,991	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			1,451			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 LINES 118-201)	173,104	40,090	48,674	141,108	20,991	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS DEPARTMENT						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	58,433					13
14 CENTRAL SERVICES & SUPPLY		4,927				14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY			49,549			16
17 SOCIAL SERVICE				14,937		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	22,299		11,532	10,954	322,779	30
31 INTENSIVE CARE UNIT					16,341	31
44 SKILLED NURSING FACILITY			284	3,983	139,413	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	11,038		3,835		163,820	50
53 ANESTHESIOLOGY					5,818	53
54 RADIOLOGY-DIAGNOSTIC			9,118		301,423	54
60 LABORATORY			6,436		133,297	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					23,555	65
66 PHYSICAL THERAPY			2,816		68,812	66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		797			42,004	71
72 IMPL. DEV. CHARGED TO PATIENTS		4,130			52,813	72
73 DRUGS CHARGED TO PATIENTS					41,792	73
74 RENAL DIALYSIS						74
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			4,184		264,810	88
88.01 RHC II					17,242	88.01
88.02 RHC III					30,247	88.02
88.03 RHC IV					103,002	88.03
88.04 RHC V					24,126	88.04
90 CLINIC					35,581	90
91 EMERGENCY	25,096		11,210		217,035	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES			134		40,500	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	58,433	4,927	49,549	14,937	2,044,410	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					41,357	190
193.01 ASSISTED LIVING					22	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)	58,433	4,927	49,549	14,937	2,085,789	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	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 DEPARTMENT			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 SERVICES-SALARY & FRINGES APPRVD			21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	322,779		30
31 INTENSIVE CARE UNIT	16,341		31
44 SKILLED NURSING FACILITY	139,413		44
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	163,820		50
53 ANESTHESIOLOGY	5,818		53
54 RADIOLOGY-DIAGNOSTIC	301,423		54
60 LABORATORY	133,297		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY	23,555		65
66 PHYSICAL THERAPY	68,812		66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	42,004		71
72 IMPL. DEV. CHARGED TO PATIENTS	52,813		72
73 DRUGS CHARGED TO PATIENTS	41,792		73
74 RENAL DIALYSIS			74
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	264,810		88
88.01 RHC II	17,242		88.01
88.02 RHC III	30,247		88.02
88.03 RHC IV	103,002		88.03
88.04 RHC V	24,126		88.04
90 CLINIC	35,581		90
91 EMERGENCY	217,035		91
92 OBSERVATION BEDS (NON-DISTINCT PART)			92
OTHER REIMBURSABLE COST CENTERS			
94 HOME PROGRAM DIALYSIS			94
95 AMBULANCE SERVICES	40,500		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)	2,044,410		118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	41,357		190
193.01 ASSISTED LIVING	22		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)	2,085,789		202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT 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 DEPARTMENT			9,501,051			4
5 ADMINISTRATIVE & GENERAL	27,648	27,648	928,693	-9,062,703	18,017,667	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,931	2,931	220,338		893,271	7
8 LAUNDRY & LINEN SERVICE	834	834			33,561	8
9 HOUSEKEEPING	666	666	150,223		296,603	9
10 DIETARY	2,602	2,602	182,267		298,850	10
11 CAFETERIA	423	423			17,022	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	689	689	327,233		420,342	13
14 CENTRAL SERVICES & SUPPLY					79,785	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	844	844	98,337		146,708	16
17 SOCIAL SERVICE	301	301			12,112	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SERVICES-SALARY & FRINGES APPRVD						21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,015	3,015	739,288		1,421,594	30
31 INTENSIVE CARE UNIT						31
44 SKILLED NURSING FACILITY					47,525	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,565	1,565	439,001		1,192,875	50
53 ANESTHESIOLOGY			4,618		90,786	53
54 RADIOLOGY-DIAGNOSTIC	3,570	3,570	622,178		1,966,855	54
60 LABORATORY	1,323	1,323	411,544		1,009,764	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	490	490			19,718	65
66 PHYSICAL THERAPY	669	669	249,309		473,898	66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	724	724			114,641	71
72 IMPL. DEV. CHARGED TO PATIENTS					788,403	72
73 DRUGS CHARGED TO PATIENTS	251	251	21,170		484,525	73
74 RENAL DIALYSIS						74
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			1,901,257		3,039,172	88
88.01 RHC II			196,958		279,228	88.01
88.02 RHC III			309,989		489,832	88.02
88.03 RHC IV			1,271,861		1,668,076	88.03
88.04 RHC V			206,339		390,713	88.04
90 CLINIC	717	717			28,853	90
91 EMERGENCY	1,637	1,637	823,260		1,621,313	91
92 OBSERVATION BEDS (NON-DISTINCT PART)						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES			397,188		653,707	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	9,501,051	-9,062,703	17,979,732	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	934	934			37,585	190
193.01 ASSISTED LIVING					350	193.01
193.02 WATSEKA CLINIC						193.02
194 FOUNDATION						194

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11  
 02/26/2014 13:47

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,452,186	633,603	77,302		9,062,703	202
203 UNIT COST MULT-WS B PT I	28.016630	12.223931	0.008136		0.502990	203
204 COST TO BE ALLOC PER B PT II					1,112,573	204
205 UNIT COST MULT-WS B PT II					0.061749	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	8	10	11	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7	32,389					7
8	834	103,383				8
9	666		31,333			9
10	2,602		2,602	82,727		10
11	423		423		154,195	11
12						12
13	689		689			13
14						14
15						15
16	844		844		5,178	16
17	301		301			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	22,511	30
31	2,369		2,369			31
44				77,511		44
ANCILLARY SERVICE COST CENTERS						
50	1,565		1,565		11,143	50
53					1,560	53
54	3,570		3,570		18,882	54
60	1,323		1,323		15,755	60
62.30						62.30
65	490					65
66	669	10,216	669		9,080	66
71	724		724			71
72						72
73	251		251		305	73
74						74
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88	9,700		9,700		44,446	88
88.01						88.01
88.02						88.02
88.03						88.03
88.04						88.04
90	717		717			90
91	1,637		1,637		25,335	91
92						92
OTHER REIMBURSABLE COST CENTERS						
94						94
95						95
99.10						99.10
99.20						99.20
99.30						99.30
99.40						99.40
SPECIAL PURPOSE COST CENTERS						
118	32,389	103,383	30,399	82,727	154,195	118
NONREIMBURSABLE COST CENTERS						
190			934			190
193.01						193.01
193.02						193.02
194						194

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11  
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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	8	10	11		
200	CROSS FOOT ADJUSTMENTS					200	
201	NEGATIVE COST CENTER					201	
202	COST TO BE ALLOC PER B PT I	1,342,577	85,013	473,398	596,339	49,509	202
203	UNIT COST MULT-WS B PT I	41.451635	0.822311	15.108608	7.208517	0.321080	203
204	COST TO BE ALLOC PER B PT II	173,104	40,090	48,674	141,108	20,991	204
205	UNIT COST MULT-WS B PT II	5.344531	0.387781	1.553442	1.705707	0.136133	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					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	58,989				13
14 CENTRAL SERVICES & SUPPLY		528,309			14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY			9,238		16
17 SOCIAL SERVICE				30	17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SERVICES-SALARY & FRINGES APPRVD					21
22 I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	22,511		2,150	22	30
31 INTENSIVE CARE UNIT					31
44 SKILLED NURSING FACILITY			53	8	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	11,143		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					65
66 PHYSICAL THERAPY			525		66
71 MEDICAL SUPPLIES CHARGED TO PATIENTS		85,507			71
72 IMPL. DEV. CHARGED TO PATIENTS		442,802			72
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
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			780		88
88.01 RHC II					88.01
88.02 RHC III					88.02
88.03 RHC IV					88.03
88.04 RHC V					88.04
90 CLINIC					90
91 EMERGENCY	25,335		2,090		91
92 OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
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)	58,989	528,309	9,238	30	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

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	670,740	119,916	269,901	35,229	202
203 UNIT COST MULT-WS B PT I	11.370595	0.226981	29.216389	1,174.300000	203
204 COST TO BE ALLOC PER B PT II	58,433	4,927	49,549	14,937	204
205 UNIT COST MULT-WS B PT II	0.990575	0.009326	5.363607	497.900000	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	2,773,224		2,773,224		2,773,224	30
31 INTENSIVE CARE UNIT	133,991		133,991		133,991	31
44 SKILLED NURSING FACILITY	641,111		641,111		641,111	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,032,567		2,032,567		2,032,567	50
53 ANESTHESIOLOGY	136,951		136,951		136,951	53
54 RADIOLOGY-DIAGNOSTIC	3,213,814		3,213,814		3,213,814	54
60 LABORATORY	1,632,614		1,632,614		1,632,614	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	49,947		49,947		49,947	65
66 PHYSICAL THERAPY	776,758		776,758		776,758	66
71 MEDICAL SUPPLIES CHARGED TO	232,662		232,662		232,662	71
72 IMPL. DEV. CHARGED TO PATIE	1,285,470		1,285,470		1,285,470	72
73 DRUGS CHARGED TO PATIENTS	742,530		742,530		742,530	73
74 RENAL DIALYSIS						74
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	5,153,532		5,153,532		5,153,532	88
88.01 RHC II	419,677		419,677		419,677	88.01
88.02 RHC III	736,213		736,213		736,213	88.02
88.03 RHC IV	2,507,102		2,507,102		2,507,102	88.03
88.04 RHC V	587,238		587,238		587,238	88.04
90 CLINIC	83,920		83,920		83,920	90
91 EMERGENCY	2,886,677		2,886,677		2,886,677	91
92 OBSERVATION BEDS (NON-DISTI	495,889		495,889		495,889	92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
95 AMBULANCE SERVICES	983,245		983,245		983,245	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)	27,505,132		27,505,132		27,505,132	200
201 LESS OBSERVATION BEDS	495,889		495,889		495,889	201
202 TOTAL (SEE INSTRUCTIONS)	27,009,243		27,009,243		27,009,243	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	3,723,767		3,723,767				30
31 INTENSIVE CARE UNIT							31
44 SKILLED NURSING FACILITY							44
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	502,189	5,440,218	5,942,407	0.342044	0.342044	0.342044	50
53 ANESTHESIOLOGY		1,410,568	1,410,568	0.097089	0.097089	0.097089	53
54 RADIOLOGY-DIAGNOSTIC	1,303,869	12,010,579	13,314,448	0.241378	0.241378	0.241378	54
60 LABORATORY	1,066,369	8,822,440	9,888,809	0.165097	0.165097	0.165097	60
62.30 BLOOD CLOTTING FOR HEMOPHIL							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY	281,257	1,368,607	1,649,864	0.470801	0.470801	0.470801	66
71 MEDICAL SUPPLIES CHARGED TO	464,419	645,777	1,110,196	0.209568	0.209568	0.209568	71
72 IMPL. DEV. CHARGED TO PATIE	434,426	492,572	926,998	1.386702	1.386702	1.386702	72
73 DRUGS CHARGED TO PATIENTS	654,868	1,858,875	2,513,743	0.295388	0.295388	0.295388	73
74 RENAL DIALYSIS							74
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							88
88.01 RHC II							88.01
88.02 RHC III							88.02
88.03 RHC IV							88.03
88.04 RHC V							88.04
90 CLINIC							90
91 EMERGENCY	654,335	7,342,476	7,996,811	0.360979	0.360979	0.360979	91
92 OBSERVATION BEDS (NON-DISTI		1,034,862	1,034,862	0.479184	0.479184	0.479184	92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
95 AMBULANCE SERVICES		1,827,095	1,827,095	0.538147	0.538147	0.538147	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)	9,085,499	42,254,069	51,339,568				200
201 LESS OBSERVATION BEDS							201
202 TOTAL (SEE INSTRUCTIONS)	9,085,499	42,254,069	51,339,568				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	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS			
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7		
50 ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.342044		1,408,289			481,697		50	
53 ANESTHESIOLOGY	0.097089							53	
54 RADIOLOGY-DIAGNOSTIC	0.241378		2,914,128			703,406		54	
60 LABORATORY	0.165097		2,218,540			366,274		60	
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30	
65 RESPIRATORY THERAPY								65	
66 PHYSICAL THERAPY	0.470801		389,038			183,159		66	
71 MEDICAL SUPPLIES CHARGED TO PAT	0.209568		580,474			121,649		71	
72 IMPL. DEV. CHARGED TO PATIENTS	1.386702		160,602			222,707		72	
73 DRUGS CHARGED TO PATIENTS	0.295388		553,669	2,604		163,547	769	73	
74 RENAL DIALYSIS								74	
76.97 CARDIAC REHABILITATION								76.97	
76.98 HYPERBARIC OXYGEN THERAPY								76.98	
76.99 LITHOTRIPSY								76.99	
88 OUTPATIENT SERVICE COST CENTERS									
88 RURAL HEALTH CLINIC								88	
88.01 RHC II								88.01	
88.02 RHC III								88.02	
88.03 RHC IV								88.03	
88.04 RHC V								88.04	
90 CLINIC								90	
91 EMERGENCY	0.360979		1,738,798			627,670		91	
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS)	0.479184		375,353			179,863		92	
94 HOME PROGRAM DIALYSIS								94	
95 AMBULANCE SERVICES	0.538147							95	
200 SUBTOTAL (SEE INSTRUCTIONS)			10,338,891	2,604		3,049,972	769	200	
201 LESS PBP CLINIC LAB SERVICES								201	
202 NET CHARGES (LINE 200 - LINE 201)			10,338,891	2,604		3,049,972	769	202	



APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1				SCHOOL 2	HEALTH 3
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
71 MEDICAL SUPPLIES CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
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						88
88.01 RHC II						88.01
88.02 RHC III						88.02
88.03 RHC IV						88.03
88.04 RHC V						88.04
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	5,942,407						50
53 ANESTHESIOLOGY	1,410,568						53
54 RADIOLOGY-DIAGNOSTIC	13,314,448			1,168			54
60 LABORATORY	9,888,809			1,145			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY	1,649,864			64,790			66
71 MEDICAL SUPPLIES CHARGED TO	1,110,196			240			71
72 IMPL. DEV. CHARGED TO PATIEN	926,998						72
73 DRUGS CHARGED TO PATIENTS	2,513,743			11,164			73
74 RENAL DIALYSIS							74
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							88
88.01 RHC II							88.01
88.02 RHC III							88.02
88.03 RHC IV							88.03
88.04 RHC V							88.04
90 CLINIC							90
91 EMERGENCY	7,996,811						91
92 OBSERVATION BEDS (NON-DISTIN	1,034,862						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
95 AMBULANCE SERVICES							95
200 TOTAL (SUM OF LINES 50-199)	45,788,706			78,507			200



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	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	322,779	74,441	248,338	1,450	171.27	30	5,138	30
32 INTENSIVE CARE UNIT	16,341		16,341					31
33 CORONARY CARE UNIT								32
34 BURN INTENSIVE CARE UNIT								33
35 SURGICAL INTENSIVE CARE UNIT								34
40 OTHER SPECIAL CARE (SPECIFY)								35
41 SUBPROVIDER - IPF								40
42 SUBPROVIDER - IRF								41
43 SUBPROVIDER I								42
44 NURSERY								43
45 SKILLED NURSING FACILITY	139,413		139,413	2,228	62.57	1,545	96,671	44
200 NURSING FACILITY								45
TOTAL (LINES 30-199)	478,533		404,092	3,678		1,575	101,809	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-1316) [ ] IPF [ ] IRF	[ ] SUB (OTHER)	[ ] PPS [ ] TEFRA [XX] OTHER					
		CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 + COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5			
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	163,820	5,942,407	0.027568					50
53	ANESTHESIOLOGY	5,818	1,410,568	0.004125					53
54	RADIOLOGY-DIAGNOSTIC	301,423	13,314,448	0.022639					54
60	LABORATORY	133,297	9,888,809	0.013480					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA								62.30
65	RESPIRATORY THERAPY	23,555							65
66	PHYSICAL THERAPY	68,812	1,649,864	0.041708					66
71	MEDICAL SUPPLIES CHARGED TO P	42,004	1,110,196	0.037835					71
72	IMPL. DEV. CHARGED TO PATIENT	52,813	926,998	0.056972					72
73	DRUGS CHARGED TO PATIENTS	41,792	2,513,743	0.016625					73
74	RENAL DIALYSIS								74
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	264,810							88
88.01	RHC II	17,242							88.01
88.02	RHC III	30,247							88.02
88.03	RHC IV	103,002							88.03
88.04	RHC V	24,126							88.04
90	CLINIC	35,581							90
91	EMERGENCY	217,035	7,996,811	0.027140					91
92	OBSERVATION BEDS (NON-DISTINC OTHER REIMBURSABLE COST CENTERS	75,018	1,034,862	0.072491					92
94	HOME PROGRAM DIALYSIS								94
95	AMBULANCE SERVICES								95
200	TOTAL (SUM OF LINES 50-199)	1,600,395	45,788,706						200

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

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

COST CENTER DESCRIPTION	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 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

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	
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS	1,450		30		31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
40 OTHER SPECIAL CARE (SPECIFY)					40
41 SUBPROVIDER - IPF					41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY	2,228		1,545		45
200 NURSING FACILITY					200
TOTAL (SUM OF LINES 30-199)	3,678		1,575		

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H  
 PERIOD FROM 10/01/2012 TO 09/30/2013

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

VERSION: 2013.11  
 02/26/2014 13:47

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					
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
71 MEDICAL SUPPLIES CHARGED TO P						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
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						88
88.01 RHC II						88.01
88.02 RHC III						88.02
88.03 RHC IV						88.03
88.04 RHC V						88.04
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS (NON-DISTINC						92
OTHER REIMBURSABLE COST CENTERS						
94 HOME PROGRAM DIALYSIS						94
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) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	5,942,407						50
53 ANESTHESIOLOGY	1,410,568						53
54 RADIOLOGY-DIAGNOSTIC	13,314,448						54
60 LABORATORY	9,888,809						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY							65
66 PHYSICAL THERAPY	1,649,864						66
71 MEDICAL SUPPLIES CHARGED TO	1,110,196						71
72 IMPL. DEV. CHARGED TO PATIEN	926,998						72
73 DRUGS CHARGED TO PATIENTS	2,513,743						73
74 RENAL DIALYSIS							74
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							88
88.01 RHC II							88.01
88.02 RHC III							88.02
88.03 RHC IV							88.03
88.04 RHC V							88.04
90 CLINIC							90
91 EMERGENCY	7,996,811						91
92 OBSERVATION BEDS (NON-DISTIN	1,034,862						92
OTHER REIMBURSABLE COST CENTERS							
94 HOME PROGRAM DIALYSIS							94
95 AMBULANCE SERVICES	1,827,095						95
200 TOTAL (SUM OF LINES 50-199)	45,788,706						200



WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,042	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,450	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,113	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	107	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)	314	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	51	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)	120	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	639	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)	99	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	291	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)	2,773,224	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)	5,987	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	14,088	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	639,572	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,133,652	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		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)		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)	2,133,652	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)				1,471.49	38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)				940,282.39	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)				940,282.41	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	133,991				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)					662,503.48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,602,785.49

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)				145,678.64	64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)				428,204.65	65
66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)				573,882.66	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)					337.87
88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)				1,471.48	88
89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)				495,889.89	89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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
90 CAPITAL-RELATED COST		322,779	2,133,652	0.151280	495,889	75,018.90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93



COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [ ] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [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)	641,111	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	287.75	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	54,385	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)	54,385	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)	54,385	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	34,322	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	88,707	86

WORKSHEET D-1  
 PART I

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)	2,042	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,450	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,113	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	107	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)	314	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	51	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)	120	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	30	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	117.40	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.40	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,773,224	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)	5,987	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	14,088	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	639,572	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,133,652	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		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)		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)	2,133,652	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) 1,471.49 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 44,145 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) 44,145 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	133,991				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)					44,145 49
PASS-THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					5,138 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					5,138 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) 337 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

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	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		1,637,740		30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.342044	208,472	71,307	50
53 ANESTHESIOLOGY	0.097089			53
54 RADIOLOGY-DIAGNOSTIC	0.241378	351,941	84,951	54
60 LABORATORY	0.165097	337,788	55,768	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY				65
66 PHYSICAL THERAPY	0.470801	34,172	16,088	66
71 MEDICAL SUPPLIES CHARGED TO PAT	0.209568	237,614	49,796	71
72 IMPL. DEV. CHARGED TO PATIENTS	1.386702	215,568	298,929	72
73 DRUGS CHARGED TO PATIENTS	0.295388	257,689	76,118	73
74 RENAL DIALYSIS				74
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				88
88.01 RHC II				88.01
88.02 RHC III				88.02
88.03 RHC IV				88.03
88.04 RHC V				88.04
90 CLINIC				90
91 EMERGENCY	0.360979	26,445	9,546	91
92 OBSERVATION BEDS (NON-DISTINCT	0.479184			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,669,689	662,503	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,669,689		202

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	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.342044			50
53 ANESTHESIOLOGY	0.097089			53
54 RADIOLOGY-DIAGNOSTIC	0.241378	46,232	11,159	54
60 LABORATORY	0.165097	31,623	5,221	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY				65
66 PHYSICAL THERAPY	0.470801	145,525	68,513	66
71 MEDICAL SUPPLIES CHARGED TO PAT	0.209568	38,282	8,023	71
72 IMPL. DEV. CHARGED TO PATIENTS	1.386702			72
73 DRUGS CHARGED TO PATIENTS	0.295388	62,303	18,404	73
74 RENAL DIALYSIS				74
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				88
88.01 RHC II				88.01
88.02 RHC III				88.02
88.03 RHC IV				88.03
88.04 RHC V				88.04
90 CLINIC				90
91 EMERGENCY	0.360979			91
92 OBSERVATION BEDS (NON-DISTINCT	0.479184			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		323,965	111,320	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		323,965		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	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.342044			50
53 ANESTHESIOLOGY	0.097089			53
54 RADIOLOGY-DIAGNOSTIC	0.241378	1,168	282	54
60 LABORATORY	0.165097	1,145	189	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY				65
66 PHYSICAL THERAPY	0.470801	64,790	30,503	66
71 MEDICAL SUPPLIES CHARGED TO PAT	0.209568	240	50	71
72 IMPL. DEV. CHARGED TO PATIENTS	1.386702			72
73 DRUGS CHARGED TO PATIENTS	0.295388	11,164	3,298	73
74 RENAL DIALYSIS				74
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				88
88.01 RHC II				88.01
88.02 RHC III				88.02
88.03 RHC IV				88.03
88.04 RHC V				88.04
90 CLINIC				90
91 EMERGENCY	0.360979			91
92 OBSERVATION BEDS (NON-DISTINCT	0.479184			92
OTHER REIMBURSABLE COST CENTERS				
94 HOME PROGRAM DIALYSIS				94
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		78,507	34,322	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		78,507		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST		INPATIENT		INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3
	TO CHARGES 1		PROGRAM CHARGES 2		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.342044				50
53 ANESTHESIOLOGY	0.097089				53
54 RADIOLOGY-DIAGNOSTIC	0.241378				54
60 LABORATORY	0.165097				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY	0.470801				66
71 MEDICAL SUPPLIES CHARGED TO PAT	0.209568				71
72 IMPL. DEV. CHARGED TO PATIENTS	1.386702				72
73 DRUGS CHARGED TO PATIENTS	0.295388				73
74 RENAL DIALYSIS					74
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					88
88.01 RHC II					88.01
88.02 RHC III					88.02
88.03 RHC IV					88.03
88.04 RHC V					88.04
90 CLINIC					90
91 EMERGENCY	0.360979				91
92 OBSERVATION BEDS (NON-DISTINCT	0.479184				92
OTHER REIMBURSABLE COST CENTERS					
94 HOME PROGRAM DIALYSIS					94
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                                [ ] IPF                                [ ] IRF  
                                  [ ] SUB (OTHER)                                [XX] SNF (14-5470)

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)		40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		40.01
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)		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  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		1,118,801		1,148,538
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
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 09/27/2013	2,737		3.01
	.02			3.02
	PROGRAM .03			3.03
	TO .04			3.04
	PROVIDER .05			3.05
	.06			3.06
	.07			3.07
	.08		09/27/2013	66,869
	.09			3.08
	.50	NONE		3.09
	.51			3.50
	PROVIDER .52			3.51
	TO .53			3.52
	PROGRAM .54			3.53
	.55			3.54
	.56			3.55
	.57			3.56
	.58			3.57
	.59			3.58
	.99	2,737		3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)				66,869
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,154,742		1,516,824

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	323,050		153,953	6.01
	TO PROVIDER .02				6.02
	PROVIDER .02				6.02
	TO PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,477,792		1,670,777	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)	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT		
DESCRIPTION							1	2	3	4		
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER							469,725			1	
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.							NONE		NONE	2	
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM 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	09/27/2013		79,780	NONE	3.01
							.02					3.02
							.03					3.03
							.04					3.04
							.05					3.05
							.06					3.06
							.07					3.07
							.08					3.08
							.09					3.09
							.50	03/12/2010		7,392	NONE	3.50
							.51					3.51
							.52					3.52
							.53					3.53
							.54					3.54
							.55					3.55
							.56					3.56
							.57					3.57
							.58					3.58
							.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)						.99			72,388		3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)									542,113		4
TO BE COMPLETED BY CONTRACTOR												
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.						.01			NONE	NONE	5.01
							.02					5.02
							.03					5.03
							.04					5.04
							.05					5.05
							.06					5.06
							.07					5.07
							.08					5.08
							.09					5.09
							.50			NONE	NONE	5.50
							.51					5.51
							.52					5.52
							.53					5.53
							.54					5.54
							.55					5.55
							.56					5.56
							.57					5.57
							.58					5.58
							.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT						.01			144,570		6.01
							.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)									686,683		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	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	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	NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 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 TO .01 PROVIDER PROVIDER TO .02 PROGRAM	3,510		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		350,979		7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

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	476 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	639 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,113 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	51,339,568 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	484,229 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	380,217 8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	9 9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	10 10
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	400,747 30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	-20,530 32

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)	579,621	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)	112,433	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	390	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)	692,054	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	692,054	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	692,054	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	5,371	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)	686,683	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		17
17.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17.01
18 ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SEE INSTRUCTIONS)	686,683	19
19.01 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	6,867	19.01
20 INTERIM PAYMENTS	542,113	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	137,703	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, 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	1,602,785	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,602,785	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,618,813	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)	1,618,813	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	172,392	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,446,421	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,446,421	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	35,649	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	31,371	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	32,087	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,477,792	28
29	OTHER ADJUSTMENTS (LOSS ON SALE OF ASSETS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,477,792	30
30.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	14,778	30.01
31	INTERIM PAYMENTS	1,154,742	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS LINES 30.01, 31 AND 32)	308,272	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	670,873	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	ADJUSTED 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)	3,509 14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	350,979 15
15.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	3,510 15.01
16	INTERIM PAYMENTS	347,469 16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS 15.01, 16 AND 17)	18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES	44,145	1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	44,145	4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	44,145	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES		8
9 ANCILLARY SERVICE CHARGES		9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)		15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	44,145	21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21	44,145	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	44,145	31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	44,145	36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)	44,145	38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	44,145	40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	44,145	42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
<b>CURRENT ASSETS</b>				
1 CASH ON HAND AND IN BANKS	6,289,724			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	16,004,525			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-9,855,410			6
7 INVENTORY				7
8 PREPAID EXPENSES	44,083			8
9 OTHER CURRENT ASSETS	1,922,293			9
10 DUE FROM OTHER FUNDS	5,064,379			10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	19,469,594			11
<b>FIXED ASSETS</b>				
12 LAND	97,500			12
13 LAND IMPROVEMENTS	921,036			13
14 ACCUMULATED DEPRECIATION	-59,355			14
15 BUILDINGS	10,066,850			15
16 ACCUMULATED DEPRECIATION	-577,019			16
17 LEASEHOLD IMPROVEMENTS	21,591			17
18 ACCUMULATED AMORTIZATION	-1,286			18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	6,610,367			23
24 ACCUMULATED DEPRECIATION	-811,595			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)	16,268,089			30
<b>OTHER ASSETS</b>				
31 INVESTMENTS	3,573,229			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	4,490,639			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	8,063,868			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	43,801,551			36
<b>LIABILITIES AND FUND BALANCES</b>				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
<b>CURRENT LIABILITIES</b>				
37 ACCOUNTS PAYABLE	39,706			37
38 SALARIES, WAGES & FEES PAYABLE	870,752			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)				40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	26,632,282			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	27,542,740			45
<b>LONG-TERM LIABILITIES</b>				
46 MORTGAGE PAYABLE	11,482,301			46
47 NOTES PAYABLE				47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES				49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	11,482,301			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	39,025,041			51
<b>CAPITAL ACCOUNTS</b>				
52 GENERAL FUND BALANCE	4,776,510			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)	4,776,510			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	43,801,551			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		6,249,560							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-1,473,050							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		4,776,510							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)		4,776,510							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)		4,776,510							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	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	9,086,064		9,086,064	1
2 SUBPROVIDER IPF				2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY	28,362		28,362	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	9,114,426		9,114,426	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT				11
12 CORONARY CARE UNIT				12
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	9,114,426		9,114,426	17
18 ANCILLARY SERVICES				18
19 OUTPATIENT SERVICES		42,226,843	42,226,843	19
20 RHC		3,467,332	3,467,332	20
20.01 RHC II		375,446	375,446	20.01
20.02 RHC III		482,493	482,493	20.02
20.03 RHC IV		1,721,083	1,721,083	20.03
20.04 RHC V		291,678	291,678	20.04
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 PROFESSIONAL FEES		323,941	323,941	27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	9,114,426	48,888,816	58,003,242	28

PART II - OPERATING EXPENSES

29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)	1	2	27,154,243	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)			27,154,243	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	58,003,242	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	32,942,696	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	25,060,546	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	27,154,243	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-2,093,697	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		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		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		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		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (TRUST INCOME)		24
24.01	OTHER (MISCELLANEOUS INCOME)		24.01
24.02	OTHER (UNREALIZED GAINS)		24.02
24.03	OTHER (GRANTS)		24.03
24.04	OTHER (CATERING)		24.04
24.05	OTHER (LOSS ON DISPOSAL)		24.05
24.06	OTHER (COUNTY TERRACE)		24.06
24.07	OTHER (NET OTHER INCOME)	620,647	24.07
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	620,647	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,473,050	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)	-1,473,050	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)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS DEPARTMENT					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 SERVICES-SALARY & FRINGES					21
22 I&R SERVICES-OTHER PRGM COSTS					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
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 HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
71 MEDICAL SUPPLIES CHARGED TO PA					71
72 IMPL. DEV. CHARGED TO PATIENTS					72
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC					88
88.01 RHC II					88.01
88.02 RHC III					88.02
88.03 RHC IV					88.03
88.04 RHC V					88.04
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS					92
94 HOME PROGRAM DIALYSIS					94
95 AMBULANCE SERVICES					95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					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

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

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN								1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	1,854,628	1,256,580	3,111,208	-86,448	3,024,760	-1,058	3,023,702	9
10 SUBTOTAL (SUM OF LINES 1-9)	1,854,628	1,256,580	3,111,208	-86,448	3,024,760	-1,058	3,023,702	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES								15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)								21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,854,628	1,256,580	3,111,208	-86,448	3,024,760	-1,058	3,023,702	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS								30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)								31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,854,628	1,256,580	3,111,208	-86,448	3,024,760	-1,058	3,023,702	32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET M-2

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	2.18	6,458	4,200	9,156	1
2	PHYSICIAN ASSISTANTS	3.37	16,554	2,100	7,077	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	5.55	23,012		16,233	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5.55	23,012			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)				3,023,702	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)				3,023,702	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)				2,129,830	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				2,129,830	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				2,129,830	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				2,129,830	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				5,153,532	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)		5,153,532	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)		506,572	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)		4,646,960	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)		23,012	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)			5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)		23,012	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)		201.94	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. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)				8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	201.94	201.94	201.94	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,023	3,013		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	206,585	608,445		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)		815,030		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%)		615,004		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		615,004		16.05
17	PRIMARY PAYOR PAYMENTS		79		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		46,275		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		101,201		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		614,925		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		144,885		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		759,810		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		4,105		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		3,612		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		156		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		763,422		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		7,634		26.01
27	INTERIM PAYMENTS		445,144		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		310,644		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		12,055		30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	3,023,702	3,023,702	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.049000	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		148,161	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)		149,057	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		297,218	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	3,023,702	3,023,702	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	2,129,830	2,129,830	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.098296	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		209,354	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		506,572	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		14,729	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		34.39	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		4,213	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		144,885	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)		506,572	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)		144,885	16

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

RHC I  
 COMPONENT NO: 14-3448

WORKSHEET M-5

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		431,512	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 09/27/2013	13,632	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	13,632	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		445,144	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99		5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01	318,278	6.01
	PROVIDER PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)	PROGRAM	763,422	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	8
		NPR DATE:	

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

RHC II  
 COMPONENT NO: 14-3485

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7
FACILITY HEALTH CARE STAFF COSTS							
1 PHYSICIAN							1
2 PHYSICIAN ASSISTANT							2
3 NURSE PRACTITIONER							3
4 VISITING NURSE							4
5 OTHER NURSE							5
6 CLINICAL PSYCHOLOGIST							6
7 CLINICAL SOCIAL WORKER							7
8 LABORATORY TECHNICIAN							8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	196,958	80,668	277,626		277,626		277,626 9
10 SUBTOTAL (SUM OF LINES 1-9)	196,958	80,668	277,626		277,626		277,626 10
COSTS UNDER AGREEMENT							
11 PHYSICIAN SERVICES UNDER AGREEMENT							11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13 OTHER COSTS UNDER AGREEMENT							13
14 SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS							
15 MEDICAL SUPPLIES							15
16 TRANSPORTATION (HEALTH CARE STAFF)							16
17 DEPRECIATION-MEDICAL EQUIPMENT							17
18 PROFESSIONAL LIABILITY INSURANCE							18
19 OTHER HEALTH CARE COSTS							19
20 ALLOWABLE GME COSTS							20
21 SUBTOTAL (SUM OF LINES 15-20)							21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	196,958	80,668	277,626		277,626		277,626 22
COSTS OTHER THAN RHC/FQHC SERVICES							
23 PHARMACY							23
24 DENTAL							24
25 OPTOMETRY							25
26 ALL OTHER NONREIMBURSABLE COSTS							26
27 NONALLOWABLE GME COSTS							27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28
FACILITY OVERHEAD							
29 FACILITY COSTS							29
30 ADMINISTRATIVE COSTS							30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)							31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	196,958	80,668	277,626		277,626		277,626 32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC II  
 COMPONENT NO: 14-3485

WORKSHEET M-2

CHECK APPLICABLE BOX [ XX ] 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		164	4,200		1
2	PHYSICIAN ASSISTANTS	0.92	2,203	2,100	1,932	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	0.92	2,367		1,932	2,367
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.92	2,367			2,367
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)				277,626	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)				277,626	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)				142,051	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				142,051	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				142,051	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				142,051	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				419,677	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)	419,677	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	59,191	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	360,486	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	2,367	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,367	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	152.30	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. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	152.30	152.30	152.30 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	158	469	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	24,063	71,429	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)		95,492	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%)		70,199	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		70,199	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		7,743	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		13,952	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		70,199	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		21,569	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		91,768	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		84	23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		74	23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		91,842	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		918	26.01
27	INTERIM PAYMENTS		65,755	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		25,169	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		1,476	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 II  
 COMPONENT NO: 14-3485

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	277,626	277,626	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.065000	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		18,046	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)		21,110	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		39,156	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	277,626	277,626	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	142,051	142,051	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.141039	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		20,035	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		59,191	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		2,086	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		28.38	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		760	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		21,569	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)		59,191	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)		21,569	16



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

RHC III  
 COMPONENT NO: 14-3496

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7
FACILITY HEALTH CARE STAFF COSTS							
1 PHYSICIAN							1
2 PHYSICIAN ASSISTANT							2
3 NURSE PRACTITIONER							3
4 VISITING NURSE							4
5 OTHER NURSE							5
6 CLINICAL PSYCHOLOGIST							6
7 CLINICAL SOCIAL WORKER							7
8 LABORATORY TECHNICIAN							8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	309,989	207,287	517,276	-29,966	487,310		487,310 9
10 SUBTOTAL (SUM OF LINES 1-9)	309,989	207,287	517,276	-29,966	487,310		487,310 10
COSTS UNDER AGREEMENT							
11 PHYSICIAN SERVICES UNDER AGREEMENT							11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13 OTHER COSTS UNDER AGREEMENT							13
14 SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS							
15 MEDICAL SUPPLIES							15
16 TRANSPORTATION (HEALTH CARE STAFF)							16
17 DEPRECIATION-MEDICAL EQUIPMENT							17
18 PROFESSIONAL LIABILITY INSURANCE							18
19 OTHER HEALTH CARE COSTS							19
20 ALLOWABLE GME COSTS							20
21 SUBTOTAL (SUM OF LINES 15-20)							21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	309,989	207,287	517,276	-29,966	487,310		487,310 22
COSTS OTHER THAN RHC/FQHC SERVICES							
23 PHARMACY							23
24 DENTAL							24
25 OPTOMETRY							25
26 ALL OTHER NONREIMBURSABLE COSTS							26
27 NONALLOWABLE GME COSTS							27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28
FACILITY OVERHEAD							
29 FACILITY COSTS							29
30 ADMINISTRATIVE COSTS							30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)							31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	309,989	207,287	517,276	-29,966	487,310		487,310 32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC III  
 COMPONENT NO: 14-3496

WORKSHEET M-2

CHECK APPLICABLE BOX [ XX ] 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	1.66	4,285	2,100	3,486	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	1.66	4,285		3,486	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.66	4,285		4,285	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)				487,310	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)				487,310	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)				248,903	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				248,903	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				248,903	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				248,903	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				736,213	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)	736,213	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	164,570	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	571,643	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	4,285	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,285	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	133.41	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. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	133.41	133.41	133.41 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	239	677	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	31,885	90,319	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)		122,204	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%)		84,822	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		84,822	16.05
17	PRIMARY PAYOR PAYMENTS		46	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		16,176	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		15,572	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		84,776	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		50,102	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		134,878	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		1,231	23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1,083	23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		135,961	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		1,360	26.01
27	INTERIM PAYMENTS		51,865	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		82,736	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		2,225	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

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	487,310	487,310	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.124000	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		60,426	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)		48,505	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		108,931	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	487,310	487,310	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	248,903	248,903	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.223535	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		55,639	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		164,570	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		4,793	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		34.34	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		1,459	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		50,102	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)		164,570	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)		50,102	16

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

RHC III  
 COMPONENT NO: 14-3496

WORKSHEET M-5

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		42,875	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 09/27/2013	8,990	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	8,990	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		51,865	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99		5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01	84,096	6.01
	PROVIDER PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		135,961	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:

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

RHC IV  
 COMPONENT NO: 14-8521

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7
FACILITY HEALTH CARE STAFF COSTS							
1 PHYSICIAN							1
2 PHYSICIAN ASSISTANT							2
3 NURSE PRACTITIONER							3
4 VISITING NURSE							4
5 OTHER NURSE							5
6 CLINICAL PSYCHOLOGIST							6
7 CLINICAL SOCIAL WORKER							7
8 LABORATORY TECHNICIAN							8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	1,271,861	427,489	1,699,350	-41,622	1,657,728		1,657,728 9
10 SUBTOTAL (SUM OF LINES 1-9)	1,271,861	427,489	1,699,350	-41,622	1,657,728		1,657,728 10
COSTS UNDER AGREEMENT							
11 PHYSICIAN SERVICES UNDER AGREEMENT							11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13 OTHER COSTS UNDER AGREEMENT							13
14 SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS							
15 MEDICAL SUPPLIES							15
16 TRANSPORTATION (HEALTH CARE STAFF)							16
17 DEPRECIATION-MEDICAL EQUIPMENT							17
18 PROFESSIONAL LIABILITY INSURANCE							18
19 OTHER HEALTH CARE COSTS							19
20 ALLOWABLE GME COSTS							20
21 SUBTOTAL (SUM OF LINES 15-20)							21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,271,861	427,489	1,699,350	-41,622	1,657,728		1,657,728 22
COSTS OTHER THAN RHC/FQHC SERVICES							
23 PHARMACY							23
24 DENTAL							24
25 OPTOMETRY							25
26 ALL OTHER NONREIMBURSABLE COSTS							26
27 NONALLOWABLE GME COSTS							27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28
FACILITY OVERHEAD							
29 FACILITY COSTS							29
30 ADMINISTRATIVE COSTS							30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)							31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,271,861	427,489	1,699,350	-41,622	1,657,728		1,657,728 32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC IV  
 COMPONENT NO: 14-8521

WORKSHEET M-2

CHECK APPLICABLE BOX [ XX ] 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	1.00	5,746	4,200	4,200	1
2	PHYSICIAN ASSISTANTS	1.80	4,341	2,100	3,780	2
3	NURSE PRACTITIONERS			2,100		3
4	SUBTOTAL (SUM OF LINES 1-3)	2.80	10,087		7,980	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.80	10,087			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,657,728	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,657,728	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)				849,374	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				849,374	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				849,374	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				849,374	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				2,507,102	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC IV  
 COMPONENT NO: 14-8521

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	2,507,102	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	224,960	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	2,282,142	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	10,087	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	10,087	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	226.25	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. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	226.25	226.25	226.25 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	662	3,852	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	149,778	871,515	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)		1,021,293	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%)		784,276	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		784,276	16.05
17	PRIMARY PAYOR PAYMENTS		39	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)		40,948	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		97,612	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		784,237	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		186,196	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		970,433	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		2,236	23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1,968	23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		19	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		972,401	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		9,724	26.01
27	INTERIM PAYMENTS		783,205	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		179,472	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		15,155	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 IV  
 COMPONENT NO: 14-8521

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,657,728	1,657,728	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.045000	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		74,598	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)		74,149	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		148,747	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,657,728	1,657,728	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	849,374	849,374	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.089729	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		76,213	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		224,960	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		7,327	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		30.70	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		6,065	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		186,196	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)		224,960	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)		186,196	16

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

RHC IV  
 COMPONENT NO: 14-8521

WORKSHEET M-5

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		469,953	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 09/27/2013	313,252	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	313,252	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		783,205	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99		5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01	189,196	6.01
	PROVIDER PROVIDER TO .02		6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		972,401	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	8
		NPR DATE:	

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

RHC V  
 COMPONENT NO: 14-8526

WORKSHEET M-1

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7
FACILITY HEALTH CARE STAFF COSTS							
1 PHYSICIAN							1
2 PHYSICIAN ASSISTANT							2
3 NURSE PRACTITIONER							3
4 VISITING NURSE							4
5 OTHER NURSE							5
6 CLINICAL PSYCHOLOGIST							6
7 CLINICAL SOCIAL WORKER							7
8 LABORATORY TECHNICIAN							8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	206,339	215,596	421,935	-32,901	389,034		389,034 9
10 SUBTOTAL (SUM OF LINES 1-9)	206,339	215,596	421,935	-32,901	389,034		389,034 10
COSTS UNDER AGREEMENT							
11 PHYSICIAN SERVICES UNDER AGREEMENT							11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13 OTHER COSTS UNDER AGREEMENT							13
14 SUBTOTAL (SUM OF LINES 11-13)							14
OTHER HEALTH CARE COSTS							
15 MEDICAL SUPPLIES							15
16 TRANSPORTATION (HEALTH CARE STAFF)							16
17 DEPRECIATION-MEDICAL EQUIPMENT							17
18 PROFESSIONAL LIABILITY INSURANCE							18
19 OTHER HEALTH CARE COSTS							19
20 ALLOWABLE GME COSTS							20
21 SUBTOTAL (SUM OF LINES 15-20)							21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	206,339	215,596	421,935	-32,901	389,034		389,034 22
COSTS OTHER THAN RHC/FQHC SERVICES							
23 PHARMACY							23
24 DENTAL							24
25 OPTOMETRY							25
26 ALL OTHER NONREIMBURSABLE COSTS							26
27 NONALLOWABLE GME COSTS							27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)							28
FACILITY OVERHEAD							
29 FACILITY COSTS							29
30 ADMINISTRATIVE COSTS							30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)							31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	206,339	215,596	421,935	-32,901	389,034		389,034 32

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC V  
 COMPONENT NO: 14-8526

WORKSHEET M-2

CHECK APPLICABLE BOX [ XX ] 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	1.38	2,100	2,898		2
3	NURSE PRACTITIONERS		2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	1.38	1,830	2,898	2,898	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.38	1,830		2,898	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)				389,034	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)				389,034	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)				198,204	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				198,204	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				198,204	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				198,204	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				587,238	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC V  
 COMPONENT NO: 14-8526

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)	587,238	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	24,386	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	562,852	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	2,898	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,898	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	194.22	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. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	194.22	194.22	194.22 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	47	491	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	9,128	95,362	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)		104,490	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%)		83,592	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		83,592	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)			18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)			19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		83,592	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		8,082	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		91,674	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		35	23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		31	23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		91,705	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		917	26.01
27	INTERIM PAYMENTS		26,900	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		63,888	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		1,383	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 V  
 COMPONENT NO: 14-8526

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	389,034	389,034	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		0.019000	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)		7,392	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)		8,763	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		16,155	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	389,034	389,034	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	198,204	198,204	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		0.041526	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)		8,231	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)		24,386	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		866	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)		28.16	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		287	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)		8,082	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)		24,386	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)		8,082	16

