HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 04-11-2014 TIME: 12:40_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [ ] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY
5. [ ] COST REPORT STATUS
1 - AS SUBMITTED
2 - SETTLED WITHOUT AUDIT
3 - SETTLED WITH AUDIT
4 - REOPENED
5 - AMENDED
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.

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 HOSPITA (14-1316) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2013 AND ENDING 12/31/2013, 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	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		250,693	93,049		22,980	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		47,705				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			107,505			10
10.01	HEALTH CLINIC - RHC II			7,739			10.01
10.02	HEALTH CLINIC - RHC III			23,026			10.02
10.03	HEALTH CLINIC - RHC IV			47,052			10.03
10.04	HEALTH CLINIC - RHC V			12,075			10.04
10.05	HEALTH CLINIC - RHC VI			71,650			10.05
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		298,398	362,096		22,980	200

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1	STREET: 701 EAST ORANGE	P.O.BOX:		1
2	CITY: HOOPSETON STATE: IL	ZIP CODE: 60942	COUNTY: VERMILLION	2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	HOOPESTON COMMUNITY MEMORIAL H	14-1316	16974	1	11/01/2001	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	HOOPESTON CMH SWING BED	14-Z316	16974		11/01/2001	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	HOOPESTON MEDICAL CENTER RHC	14-3448	16974		04/01/1998	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	CISSNA PARK	14-3485	16974		10/11/2006	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	ROSSVILLE CLINIC	14-3496	16974		10/01/2008	N	O	N	15.02
15.03	HOSPITAL-BASED HEALTH CLINIC - RHC IV	ROBERTS CLINIC	14-8521	16974		06/01/2012	N	O	N	15.03
15.04	HOSPITAL-BASED HEALTH CLINIC - RHC V	MILFORD CLINIC	14-8526	16974		07/22/2013	N	O	N	15.04
15.05	HOSPITAL-BASED HEALTH CLINIC - RHC VI	DANVILLE FAIRCHILD	14-8531	16974		12/01/2013	N	O	N	15.05
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/01/2013		TO: 12/31/2013						20
21	TYPE OF CONTROL			2						21

INPATIENT PPS INFORMATION

		1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	N	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES Or 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (SEE INSTRUCTIONS)	N	N	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.		N	23

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

		1	2	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN	N	N	39

COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)

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

		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	N			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, GENERAL SURGERY FTEs, AND PRIMARY CARE FTEs ADDED UNDER SECTION 5503) OF ACA). (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	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
1	2	3	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.

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) — 64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
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

66 ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS) — 66

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
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: — 71
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.

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: — 76
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.

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
		V	XIX	
TITLE V AND XIX INPATIENT SERVICES		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS		1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	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-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-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: 1 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 PART A 1	TITLE XVIII PART B 2	TITLE V 3	TITLE XIX 4	
155	HOSPITAL	N	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 0	COUNTY 1	STATE 2	ZIP CODE 3	CBSA 4	FTE/CAMPUS 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.			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)	10/01/2013	12/31/2013	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

		Y/N 1	DATE 2		
	PROVIDER ORGANIZATION AND OPERATION				
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N			1

		Y/N 1	DATE 2	V/I 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

		Y/N 1	TYPE 2	DATE 3	
	FINANCIAL DATA AND REPORTS				
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	N			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

		Y/N 1	Y/N 2	
	APPROVED EDUCATIONAL ACTIVITIES			
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

		Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	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

BED COMPLEMENT

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

		PART A		PART B		
		Y/N 1	DATE 2	Y/N 3	DATE 4	
	PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	01/17/2014	Y	01/17/2014	16
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		17
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		18
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		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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 RELIFED 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

		Y/N (1)	DATE (2)	
	HOME OFFICE COSTS			
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 REIMBURSMENT, INC.			42
43	PHONE NUMBER: 630-530-7100 EXT. 112	E-MAIL ADDRESS: GARY.ZEMAN@SRINC.ORG		43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30	22	8,052	20,819.00		129	9	247	1
2	HMO AND OTHER (SEE INSTRUCTIONS)									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						27		71	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		22	8,052	20,819.00		156	9	318	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		22	8,052	20,819.00		156	9	318	14
15	CAH VISITS								1	15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88					991	1,609	5,733	26
26.01	RHC II	88.01					124	77	501	26.01
26.02	RHC III	88.02					238	150	1,053	26.02
26.03	RHC IV	88.03					820	505	3,142	26.03
26.04	RHC V	88.04					118	172	566	26.04
26.05	RHC VI	88.05					1,126	1,204	5,646	26.05
27	TOTAL (SUM OF LINES 14-26)		22							27
28	OBSERVATION BED DAYS								112	28
29	AMBULANCE TRIPS						1			29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES --- TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30					46	4	107	1
2	HMO AND OTHER (SEE INSTRUCTIONS)									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)			1.00			46	4	107	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88		28.49						26
26.01	RHC II	88.01		2.98						26.01
26.02	RHC III	88.02		3.63						26.02
26.03	RHC IV	88.03		15.02						26.03
26.04	RHC V	88.04		3.71						26.04
26.05	RHC VI	88.05								26.05
27	TOTAL (SUM OF LINES 14-26)			54.83						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	2,766,699	-60,667		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)		60,271			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		15,149			2,435.00		26
27	ADMINISTRATIVE & GENERAL		171,578	-1		53,336.00		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		49,715			12,727.00		30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		34,422			13,634.00		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		41,118			14,132.00		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		77,229			6,905.00		38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		20,113			6,191.00		41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	2,766,699	-60,667	2,706,032	407,247.00	6.64	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	60,271		60,271	31,974.00	1.89	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	2,706,428	-60,667	2,645,761	375,273.00	7.05	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		54.20%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	4,140,434	-60,667	4,079,767	375,274.00	10.87	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	409,324	-1	409,323	109,360.00	3.74	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

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 0	CONTRACT LABOR 1	BENEFIT COST 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
14.05	HOSPITAL-BASED HEALTH CLINIC - RHC VI			14.05
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

PROSPECTIVE PAYMENT FOR SNF WORKSHEET S-7
STATISTICAL DATA

		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				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
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				52
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 WORKSHEET S-7
STATISTICAL DATA

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

	SNF SERVICES	CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OCT 1 OF THE COST REPORTING PERIOD (IF APPLICABLE) 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).			201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

		EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 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)				207

RHC I WORKSHEET S-8

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

COMPONENT NO: 14-3448

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 1	DATE 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

		1	2	
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.	N		10

FACILITY HOURS OF OPERATIONS(1)

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

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

RHC II WORKSHEET S-8

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

COMPONENT NO: 14-3485

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 1	DATE 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

		1	2	
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.	N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
11	CLINIC			0800	1700	0800	1900	0800	1700	0800	1900	0800	1300			11

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

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

RHC III WORKSHEET S-8

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

COMPONENT NO: 14-3496

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 1	DATE 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

		1	2	
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.	N		10

FACILITY HOURS OF OPERATIONS(1)

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

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

RHC IV WORKSHEET S-8

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

COMPONENT NO: 14-8521

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 845 S. 4TH ST.
2 CITY: WATSEKA STATE: IL ZIP CODE: 60970 COUNTY: IROQUOIS
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN

	SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 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

		1	2	
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.	N		10

FACILITY HOURS OF OPERATIONS(1)

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

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

RHC V WORKSHEET S-8

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

COMPONENT NO: 14-8526

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 322 CHICAGO STR
2 CITY: MILFROD STATE: IL. ZIP CODE: 60953 COUNTY:
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN

	SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 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

		1	2	
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.	N		10

FACILITY HOURS OF OPERATIONS(1)

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

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

RHC VI WORKSHEET S-8

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

COMPONENT NO: 14-8531

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 311 W. FAIRCHIL	1
2	CITY: DANVILLE STATE: IL ZIP CODE: 61832 COUNTY:	2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	3

	SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 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

		1	2	
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.	N		10

FACILITY HOURS OF OPERATIONS(1)

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

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

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

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)	0.471568	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)	5,298,521	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.	1,353,493	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)	1,353,493	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	599,997		599,997	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	282,939		282,939	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	282,939		282,939	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 LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)	874,375	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	51,873	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	822,502	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	387,866	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	670,805	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	2,024,298	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	CAP REL COSTS-BLDG & FIXT				159,359	1
2	00200	CAP REL COSTS-MVBLE EQUIP		483,259	483,259		2
3	00300	OTHER CAP REL COSTS					3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	15,149	16,840	31,989	25,222	4
5	00500	ADMINISTRATIVE & GENERAL	171,578	1,621,200	1,792,778	-148,176	5
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT	49,715	231,440	281,155	9,822	7
8	00800	LAUNDRY & LINEN SERVICE					8
9	00900	HOUSEKEEPING	34,422	36,284	70,706		9
10	01000	DIETARY	41,118	39,977	81,095		10
11	01100	CAFETERIA					11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	77,229	22,337	99,566		13
14	01400	CENTRAL SERVICES & SUPPLY		26,005	26,005	-23,579	14
15	01500	PHARMACY					15
16	01600	MEDICAL RECORDS & LIBRARY	20,113	5,294	25,407		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	187,326	112,628	299,954	189,360	30
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	172,908	564,880	737,788	-334,569	50
53	05300	ANESTHESIOLOGY					53
54	05400	RADIOLOGY-DIAGNOSTIC	158,527	332,873	491,400		54
60	06000	LABORATORY	113,434	150,717	264,151		60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY					65
66	06600	PHYSICAL THERAPY	80,537	35,115	115,652		66
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				23,579	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				334,569	72
73	07300	DRUGS CHARGED TO PATIENTS	8,680	124,442	133,122		73
76.97	07697	CARDIAC REHABILITATION					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
88	08800	RURAL HEALTH CLINIC	633,218	289,981	923,199	-33,170	88
88.01	08801	RHC II	50,413	13,427	63,840		88.01
88.02	08802	RHC III	87,765	30,580	118,345		88.02
88.03	08803	RHC IV	261,595	123,493	385,088	-13,009	88.03
88.04	08804	RHC V	47,845	28,016	75,861		88.04
88.05	08805	RHC VI	284,673	405,240	689,913	-48	88.05
90	09000	CLINIC					90
91	09100	EMERGENCY	210,183	341,091	551,274	-189,360	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92
		OTHER REIMBURSABLE COST CENTERS					
95	09500	AMBULANCE SERVICES	60,271	53,014	113,285		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)	2,766,699	5,088,133	7,854,832		118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
193.01	19301	ASSISTED LIVING					193.01
193.02	19302	WATSEKA CLINIC					193.02
194	07950	FOUNDATION					194
200		TOTAL (sum of lines 118-199)	2,766,699	5,088,133	7,854,832		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	159,359	-40,306	119,053	1
2	00200	CAP REL COSTS-MVBLE EQUIP	483,259		483,259	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	57,211	-2,941	54,270	4
5	00500	ADMINISTRATIVE & GENERAL	1,644,602	-187,071	1,457,531	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	290,977	194,852	485,829	7
8	00800	LAUNDRY & LINEN SERVICE				8
9	00900	HOUSEKEEPING	70,706		70,706	9
10	01000	DIETARY	81,095	-14,320	66,775	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	99,566		99,566	13
14	01400	CENTRAL SERVICES & SUPPLY	2,426	46,798	49,224	14
15	01500	PHARMACY				15
16	01600	MEDICAL RECORDS & LIBRARY	25,407	16,139	41,546	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	489,314		489,314	30
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	403,219	-60,667	342,552	50
53	05300	ANESTHESIOLOGY				53
54	05400	RADIOLOGY-DIAGNOSTIC	491,400	-110,888	380,512	54
60	06000	LABORATORY	264,151		264,151	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY				65
66	06600	PHYSICAL THERAPY	115,652	53,816	169,468	66
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,579		23,579	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	334,569		334,569	72
73	07300	DRUGS CHARGED TO PATIENTS	133,122	91,821	224,943	73
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
88	08800	RURAL HEALTH CLINIC	890,029	-66,685	823,344	88
88.01	08801	RHC II	63,840		63,840	88.01
88.02	08802	RHC III	118,345		118,345	88.02
88.03	08803	RHC IV	372,079		372,079	88.03
88.04	08804	RHC V	75,861		75,861	88.04
88.05	08805	RHC VI	689,865	-76,680	613,185	88.05
90	09000	CLINIC				90
91	09100	EMERGENCY	361,914	-178,027	183,887	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
		OTHER REIMBURSABLE COST CENTERS				
95	09500	AMBULANCE SERVICES	113,285		113,285	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)	7,854,832	-334,159	7,520,673	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
193.01	19301	ASSISTED LIVING				193.01
193.02	19302	WATSEKA CLINIC				193.02
194	07950	FOUNDATION				194
200		TOTAL (sum of lines 118-199)	7,854,832	-334,159	7,520,673	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INTEREST EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		159,358	1
500	TOTAL RECLASSIFICATIONS					159,358	500
	CODE LETTER - A						
1	SURGERY SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71		23,579	1
2			IMPL. DEV. CHARGED TO PATIENT	72		334,569	2
500	TOTAL RECLASSIFICATIONS					358,148	500
	CODE LETTER - B						
1	CAPITAL INSURANCE	C	CAP REL COSTS-BLDG & FIXT	1		1	1
500	TOTAL RECLASSIFICATIONS					1	500
	CODE LETTER - C						
1	UTILITY EXPENSE	D	OPERATION OF PLANT	7		9,822	1
2							2
500	TOTAL RECLASSIFICATIONS					9,822	500
	CODE LETTER - D						
1	BENEFITS	E	EMPLOYEE BENEFITS DEPARTMENT	4		25,222	1
500	TOTAL RECLASSIFICATIONS					25,222	500
	CODE LETTER - E						
1	INSURANCE EXPENSE	F	ADMINISTRATIVE & GENERAL	5		41,653	1
2							2
500	TOTAL RECLASSIFICATIONS					41,653	500
	CODE LETTER - F						
1	CRNA SALARIES	G	OPERATING ROOM	50		60,667	1
500	TOTAL RECLASSIFICATIONS					60,667	500
	CODE LETTER - G						
1	RECRUITING EXPENSE	I	ADMINISTRATIVE & GENERAL	5		1,548	1
2							2
500	TOTAL RECLASSIFICATIONS					1,548	500
	CODE LETTER - I						
1	RHC SPECIALTY PHYSICIAN	J	RURAL HEALTH CLINIC	88	1	1	1
500	TOTAL RECLASSIFICATIONS				1	1	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)				1	845,780	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	5		159,358	11	1
500	TOTAL RECLASSIFICATIONS					159,358		500
	CODE LETTER - A							
1	SURGERY SUPPLIES	B	CENTRAL SERVICES & SUPPLY	14		23,579		1
2			OPERATING ROOM	50		334,569		2
500	TOTAL RECLASSIFICATIONS					358,148		500
	CODE LETTER - B							
1	CAPITAL INSURANCE	C	ADMINISTRATIVE & GENERAL	5		1	11	1
500	TOTAL RECLASSIFICATIONS					1		500
	CODE LETTER - C							
1	UTILITY EXPENSE	D	ADMINISTRATIVE & GENERAL	5		6,794		1
2			RURAL HEALTH CLINIC	88		3,028		2
500	TOTAL RECLASSIFICATIONS					9,822		500
	CODE LETTER - D							
1	BENEFITS	E	ADMINISTRATIVE & GENERAL	5		25,222		1
500	TOTAL RECLASSIFICATIONS					25,222		500
	CODE LETTER - E							
1	INSURANCE EXPENSE	F	RURAL HEALTH CLINIC	88		28,644		1
2			RHC IV	88.03		13,009		2
500	TOTAL RECLASSIFICATIONS					41,653		500
	CODE LETTER - F							
1	CRNA SALARIES	G	OPERATING ROOM	50	60,667			1
500	TOTAL RECLASSIFICATIONS				60,667			500
	CODE LETTER - G							
1	RECRUITING EXPENSE	I	RURAL HEALTH CLINIC	88		1,500		1
2			RHC VI	88.05		48		2
500	TOTAL RECLASSIFICATIONS					1,548		500
	CODE LETTER - I							
1	RHC SPECIALTY PHYSICIAN	J	ADMINISTRATIVE & GENERAL	5	1	1		1
500	TOTAL RECLASSIFICATIONS				1	1		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)				60,668	785,113		

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 PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	97,500					97,500		1
2	LAND IMPROVEMENTS	921,036	94,070		94,070		1,015,106		2
3	BUILDINGS AND FIXTURES	10,066,850	153,665		153,665		10,220,515		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	3,212,615					3,212,615		5
6	MOVABLE EQUIPMENT	2,913,600	309,058		309,058		3,222,658		6
7	HIT DESIGNATED ASSETS	505,743					505,743		7
8	SUBTOTAL (SUM OF LINES 1-7)	17,717,344	556,793		556,793		18,274,137		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	17,717,344	556,793		556,793		18,274,137		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPRECIATION 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	483,259						483,259	2
3	TOTAL (SUM OF LINES 1-2)	483,259						483,259	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL 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

	DESCRIPTION	SUMMARY OF CAPITAL DEPRECIATION 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	-28,259		147,312				119,053	1
2	CAP REL COSTS-MVBLE EQUIP	483,259						483,259	2
3	TOTAL	455,000		147,312				602,312	3

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-12,047	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	-355,600				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	449,620				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-4,605	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						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	-9,715	DIETARY	10		33
34	OTHER INCOME	B	-1,173	ADMINISTRATIVE & GENERAL	5		34
35							35
36							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							40
41	PROVIDER TAX	A	-108,498	ADMINISTRATIVE & GENERAL	5		41
42							42
43	CRNA SALARIES	A	-60,667	OPERATING ROOM	50		43
43.01	CRNA BENEFITS	A	-2,941	EMPLOYEE BENEFITS DEPARTMENT	4		43.01
44	COUNTRY TERRACE RENT	B	-4,329	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	-36,419	CAP REL COSTS-BLDG & FIXT	1	9	46
47	DANVILLE IP COST	A	-76,680	RHC VI	88.05		47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-334,159				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	MANAGEMENT FEES	967,136	925,271	41,865		1
2	7	OPERATION OF PLANT		53,858	36,399	17,459		2
3	66	PHYSICAL THERAPY		166,009	112,193	53,816		3
3.01	73	DRUGS CHARGED TO PATIENTS		187,762	95,941	91,821		4.01
3.02	7	OPERATION OF PLANT	BIOMEDICAL	181,722		181,722		4.02
3.03	14	CENTRAL SERVICES & SUPPLY		46,798		46,798		4.03
3.04	16	MEDICAL RECORDS & LIBRARY		16,139		16,139		4.04
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		1,619,424	1,169,804	449,620		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.

		RELATED ORGANIZATION(S) AND/OR HOME OFFICE				
	SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
6	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 LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
3	30	ADULTS & PEDIATRICS	HOSPITALIST CAL	28,845		28,845					3
4	91	EMERGENCY	AGGREGATE	273,888	178,027	95,861					4
5	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	110,888	110,888						5
6	88	RURAL HEALTH CLINIC	AGGREGATE	66,685	66,685						6
200		TOTAL		480,306	355,600	124,706					200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT	
	10	11		12	13	14	15	16	17	18	
3	30	ADULTS & PEDIATRICS	HOSPITALIST CAL								3
4	91	EMERGENCY	AGGREGATE							178,027	4
5	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE							110,888	5
6	88	RURAL HEALTH CLINIC	AGGREGATE							66,685	6
200		TOTAL								355,600	200

PROVIDER CCN: 14-1316 HOOPESTON COMMUNITY MEMORIAL H | KPMG LLP COMPU-MAX MICRO SYSTEM | VERSION: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES | WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 | 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	TOTAL HOURS WORKED		415.00	1,798.00			9
10	AHSEA		71.23	53.43			10
11	STANDARD TRAVEL ALLOWANCE	35.62	35.62	26.72			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	29,560	15
16	ASSISTANTS	96,067	16
17	SUBTOTAL ALLOWANCE AMOUNT	125,627	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	125,627	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	125,627	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 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	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	125,627	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	12,600	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	138,227	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	101,666	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 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	TOTAL HOURS WORKED		2,095.00	1,696.00			9
10	AHSEA		71.23	53.43	35.62		10
11	STANDARD TRAVEL ALLOWANCE	35.62	35.62	26.72			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	149,227	15
16	ASSISTANTS	90,617	16
17	SUBTOTAL ALLOWANCE AMOUNT	239,844	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	239,844	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	239,844	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 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	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	239,844	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	10,999	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	250,843	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	203,154	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 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 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 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	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	55,559	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	55,559	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	9,686	64
65	EXCESS OVER LIMITATION		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	119,053	119,053				1
2	CAP REL COSTS-MVBLE EQUIP	483,259		483,259			2
4	EMPLOYEE BENEFITS DEPARTMENT	54,270			54,270		4
5	ADMINISTRATIVE & GENERAL	1,457,531	63,501	257,775	3,460	1,782,267	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	485,829	6,732	27,327	1,003	520,891	7
8	LAUNDRY & LINEN SERVICE		1,916	7,776		9,692	8
9	HOUSEKEEPING	70,706	1,530	6,209	694	79,139	9
10	DIETARY	66,775	5,976	24,259	829	97,839	10
11	CAFETERIA		972	3,944		4,916	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	99,566	1,583	6,424	1,558	109,131	13
14	CENTRAL SERVICES & SUPPLY	49,224				49,224	14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	41,546	1,939	7,869	406	51,760	16
17	SOCIAL SERVICE		691	2,806		3,497	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	489,314	6,925	28,110	3,778	528,127	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	342,552	3,595	14,591	2,264	363,002	50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	380,512	8,200	33,284	3,197	425,193	54
60	LABORATORY	264,151	3,039	12,335	2,288	281,813	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,125	4,568		5,693	65
66	PHYSICAL THERAPY	169,468	1,537	6,237	1,624	178,866	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,579	1,663	6,750		31,992	71
72	IMPL. DEV. CHARGED TO PATIENTS	334,569				334,569	72
73	DRUGS CHARGED TO PATIENTS	224,943	577	2,340	175	228,035	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	823,344			12,770	836,114	88
88.01	RHC II	63,840			1,017	64,857	88.01
88.02	RHC III	118,345			1,770	120,115	88.02
88.03	RHC IV	372,079			5,276	377,355	88.03
88.04	RHC V	75,861			965	76,826	88.04
88.05	RHC VI	613,185			5,741	618,926	88.05
90	CLINIC		1,647	6,685		8,332	90
91	EMERGENCY	183,887	3,760	15,262	4,239	207,148	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	113,285			1,216	114,501	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)	7,520,673	116,908	474,551	54,270	7,509,820	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,145	8,708		10,853	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)	7,520,673	119,053	483,259	54,270	7,520,673	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	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	1,782,267					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	161,781	682,672				7
8	LAUNDRY & LINEN SERVICE	3,010	18,966	31,668			8
9	HOUSEKEEPING	24,579	15,145		118,863		9
10	DIETARY	30,387	59,171		10,678	198,075	10
11	CAFETERIA	1,527	9,619		1,736		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	33,895	15,668		2,828		13
14	CENTRAL SERVICES & SUPPLY	15,288					14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	16,076	19,193		3,464		16
17	SOCIAL SERVICE	1,086	6,845		1,235		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	164,029	68,563	28,539	12,373	198,075	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	112,743	35,589		6,422		50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	132,059	81,184		14,651		54
60	LABORATORY	87,527	30,086		5,429		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,768	11,143				65
66	PHYSICAL THERAPY	55,553	15,213	3,129	2,745		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,936	16,464		2,971		71
72	IMPL. DEV. CHARGED TO PATIENTS	103,912					72
73	DRUGS CHARGED TO PATIENTS	70,824	5,708		1,030		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	259,687	220,584		39,808		88
88.01	RHC II	20,144					88.01
88.02	RHC III	37,306					88.02
88.03	RHC IV	117,201					88.03
88.04	RHC V	23,861					88.04
88.05	RHC VI	192,230					88.05
90	CLINIC	2,588	16,305		2,942		90
91	EMERGENCY	64,337	37,226		6,718		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	35,562					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)	1,778,896	682,672	31,668	115,030	198,075	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,371			3,833		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)	1,782,267	682,672	31,668	118,863	198,075	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11	13	14	16	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	17,798					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		161,522				13
14	CENTRAL SERVICES & SUPPLY			64,512			14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	598			91,091		16
17	SOCIAL SERVICE					12,663	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	2,598	61,639		21,321	12,663	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,286	30,511		7,091		50
53	ANESTHESIOLOGY	180					53
54	RADIOLOGY-DIAGNOSTIC	2,179			16,860		54
60	LABORATORY	1,819			11,901		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY	1,048			5,207		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			10,441			71
72	IMPL. DEV. CHARGED TO PATIENTS			54,071			72
73	DRUGS CHARGED TO PATIENTS	35					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	5,131			7,736		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
88.05	RHC VI						88.05
90	CLINIC						90
91	EMERGENCY	2,924	69,372		20,727		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES				248		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)	17,798	161,522	64,512	91,091	12,663	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)	17,798	161,522	64,512	91,091	12,663	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	1,097,927		1,097,927	30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	556,644		556,644	50
53	ANESTHESIOLOGY	180		180	53
54	RADIOLOGY-DIAGNOSTIC	672,126		672,126	54
60	LABORATORY	418,575		418,575	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	18,604		18,604	65
66	PHYSICAL THERAPY	261,761		261,761	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,804		71,804	71
72	IMPL. DEV. CHARGED TO PATIENTS	492,552		492,552	72
73	DRUGS CHARGED TO PATIENTS	305,632		305,632	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC	1,369,060		1,369,060	88
88.01	RHC II	85,001		85,001	88.01
88.02	RHC III	157,421		157,421	88.02
88.03	RHC IV	494,556		494,556	88.03
88.04	RHC V	100,687		100,687	88.04
88.05	RHC VI	811,156		811,156	88.05
90	CLINIC	30,167		30,167	90
91	EMERGENCY	408,452		408,452	91
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES	150,311		150,311	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)	7,502,616		7,502,616	118
	NONREIMBURSABLE COST CENTERS				
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,057		18,057	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)	7,520,673		7,520,673	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		63,501	257,775	321,276	321,276	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		6,732	27,327	34,059	29,163	7
8	LAUNDRY & LINEN SERVICE		1,916	7,776	9,692	543	8
9	HOUSEKEEPING		1,530	6,209	7,739	4,431	9
10	DIETARY		5,976	24,259	30,235	5,478	10
11	CAFETERIA		972	3,944	4,916	275	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		1,583	6,424	8,007	6,110	13
14	CENTRAL SERVICES & SUPPLY					2,756	14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		1,939	7,869	9,808	2,898	16
17	SOCIAL SERVICE		691	2,806	3,497	196	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		6,925	28,110	35,035	29,568	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		3,595	14,591	18,186	20,323	50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC		8,200	33,284	41,484	23,805	54
60	LABORATORY		3,039	12,335	15,374	15,778	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,125	4,568	5,693	319	65
66	PHYSICAL THERAPY		1,537	6,237	7,774	10,014	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,663	6,750	8,413	1,791	71
72	IMPL. DEV. CHARGED TO PATIENTS					18,732	72
73	DRUGS CHARGED TO PATIENTS		577	2,340	2,917	12,767	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC					46,810	88
88.01	RHC II					3,631	88.01
88.02	RHC III					6,725	88.02
88.03	RHC IV					21,127	88.03
88.04	RHC V					4,301	88.04
88.05	RHC VI					34,652	88.05
90	CLINIC		1,647	6,685	8,332	466	90
91	EMERGENCY		3,760	15,262	19,022	11,598	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES					6,411	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)		116,908	474,551	591,459	320,668	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		2,145	8,708	10,853	608	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)		119,053	483,259	602,312	321,276	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	63,222					7
8	LAUNDRY & LINEN SERVICE	1,756	11,991				8
9	HOUSEKEEPING	1,403		13,573			9
10	DIETARY	5,480		1,219	42,412		10
11	CAFETERIA	891		198		6,280	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,451		323			13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	1,777		396		211	16
17	SOCIAL SERVICE	634		141			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	6,350	10,806	1,413	42,412	917	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,296		733		454	50
53	ANESTHESIOLOGY					64	53
54	RADIOLOGY-DIAGNOSTIC	7,518		1,673		769	54
60	LABORATORY	2,786		620		642	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,032					65
66	PHYSICAL THERAPY	1,409	1,185	314		370	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,525		339			71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS	529		118		12	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	20,427		4,545		1,809	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
88.05	RHC VI						88.05
90	CLINIC	1,510		336			90
91	EMERGENCY	3,448		767		1,032	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	63,222	11,991	13,135	42,412	6,280	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			438			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)	63,222	11,991	13,573	42,412	6,280	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	15,891					13
14	CENTRAL SERVICES & SUPPLY		2,756				14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY			15,090			16
17	SOCIAL SERVICE				4,468		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	6,064		3,532	4,468	140,565	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,002		1,175		47,169	50
53	ANESTHESIOLOGY					64	53
54	RADIOLOGY-DIAGNOSTIC			2,793		78,042	54
60	LABORATORY			1,971		37,171	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY					7,044	65
66	PHYSICAL THERAPY			863		21,929	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		446			12,514	71
72	IMPL. DEV. CHARGED TO PATIENTS		2,310			21,042	72
73	DRUGS CHARGED TO PATIENTS					16,343	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC			1,281		74,872	88
88.01	RHC II					3,631	88.01
88.02	RHC III					6,725	88.02
88.03	RHC IV					21,127	88.03
88.04	RHC V					4,301	88.04
88.05	RHC VI					34,652	88.05
90	CLINIC					10,644	90
91	EMERGENCY	6,825		3,434		46,126	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES			41		6,452	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)	15,891	2,756	15,090	4,468	590,413	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					11,899	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)	15,891	2,756	15,090	4,468	602,312	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		140,565	30
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM		47,169	50
53	ANESTHESIOLOGY		64	53
54	RADIOLOGY-DIAGNOSTIC		78,042	54
60	LABORATORY		37,171	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65	RESPIRATORY THERAPY		7,044	65
66	PHYSICAL THERAPY		21,929	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		12,514	71
72	IMPL. DEV. CHARGED TO PATIENTS		21,042	72
73	DRUGS CHARGED TO PATIENTS		16,343	73
76.97	CARDIAC REHABILITATION			76.97
76.98	HYPERBARIC OXYGEN THERAPY			76.98
76.99	LITHOTRIPSY			76.99
	OUTPATIENT SERVICE COST CENTERS			
88	RURAL HEALTH CLINIC		74,872	88
88.01	RHC II		3,631	88.01
88.02	RHC III		6,725	88.02
88.03	RHC IV		21,127	88.03
88.04	RHC V		4,301	88.04
88.05	RHC VI		34,652	88.05
90	CLINIC		10,644	90
91	EMERGENCY		46,126	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			92
	OTHER REIMBURSABLE COST CENTERS			
95	AMBULANCE SERVICES		6,452	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)		590,413	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		11,899	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)		602,312	202

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	
	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			2,690,883			4
5	ADMINISTRATIVE & GENERAL	27,648	27,648	171,577	-1,782,267	5,738,406	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	2,931	2,931	49,715		520,891	7
8	LAUNDRY & LINEN SERVICE	834	834			9,692	8
9	HOUSEKEEPING	666	666	34,422		79,139	9
10	DIETARY	2,602	2,602	41,118		97,839	10
11	CAFETERIA	423	423			4,916	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	689	689	77,229		109,131	13
14	CENTRAL SERVICES & SUPPLY					49,224	14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	844	844	20,113		51,760	16
17	SOCIAL SERVICE	301	301			3,497	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	187,326		528,127	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,565	1,565	112,241		363,002	50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	3,570	3,570	158,527		425,193	54
60	LABORATORY	1,323	1,323	113,434		281,813	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	490	490			5,693	65
66	PHYSICAL THERAPY	669	669	80,537		178,866	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	724	724			31,992	71
72	IMPL. DEV. CHARGED TO PATIENTS					334,569	72
73	DRUGS CHARGED TO PATIENTS	251	251	8,680		228,035	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC			633,219		836,114	88
88.01	RHC II			50,413		64,857	88.01
88.02	RHC III			87,765		120,115	88.02
88.03	RHC IV			261,595		377,355	88.03
88.04	RHC V			47,845		76,826	88.04
88.05	RHC VI			284,673		618,926	88.05
90	CLINIC	717	717			8,332	90
91	EMERGENCY	1,637	1,637	210,183		207,148	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES			60,271		114,501	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	2,690,883	-1,782,267	5,727,553	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	934	934			10,853	190
193.01	ASSISTED LIVING						193.01
193.02	WATSEKA CLINIC						193.02
194	FOUNDATION						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	119,053	483,259	54,270		1,782,267	202
203	UNIT COST MULT-WS B PT I	2.296857	9.323385	0.020168		0.310586	203
204	COST TO BE ALLOC PER B PT II					321,276	204
205	UNIT COST MULT-WS B PT II					0.055987	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 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	30,020					7
8	LAUNDRY & LINEN SERVICE	834	103,383				8
9	HOUSEKEEPING	666		28,964			9
10	DIETARY	2,602		2,602	5,216		10
11	CAFETERIA	423		423		154,195	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	689		689			13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	844		844		5,178	16
17	SOCIAL SERVICE	301		301			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	93,167	3,015	5,216	22,511	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,565		1,565		11,143	50
53	ANESTHESIOLOGY					1,560	53
54	RADIOLOGY-DIAGNOSTIC	3,570		3,570		18,882	54
60	LABORATORY	1,323		1,323		15,755	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	490					65
66	PHYSICAL THERAPY	669	10,216	669		9,080	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	724		724			71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS	251		251		305	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	9,700		9,700		44,446	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
88.05	RHC VI						88.05
90	CLINIC	717		717			90
91	EMERGENCY	1,637		1,637		25,335	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	30,020	103,383	28,030	5,216	154,195	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			934			190
193.01	ASSISTED LIVING						193.01
193.02	WATSEKA CLINIC						193.02
194	FOUNDATION						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	682,672	31,668	118,863	198,075	17,798	202
203	UNIT COST MULT-WS B PT I	22.740573	0.306317	4.103819	37.974502	0.115425	203
204	COST TO BE ALLOC PER B PT II	63,222	11,991	13,573	42,412	6,280	204
205	UNIT COST MULT-WS B PT II	2.105996	0.115986	0.468616	8.131135	0.040728	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			9,185		16
17	SOCIAL SERVICE				22	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
	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
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
88.05	RHC VI					88.05
90	CLINIC					90
91	EMERGENCY	25,335		2,090		91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES			25		95
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)	58,989	528,309	9,185	22	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
193.01	ASSISTED LIVING					193.01
193.02	WATSEKA CLINIC					193.02
194	FOUNDATION					194
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	161,522	64,512	91,091	12,663	202
203	UNIT COST MULT-WS B PT I	2.738172	0.122110	9.917365	575.590909	203
204	COST TO BE ALLOC PER B PT II	15,891	2,756	15,090	4,468	204
205	UNIT COST MULT-WS B PT II	0.269389	0.005217	1.642896	203.090909	205

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,097,927		1,097,927			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	556,644		556,644			50
53	ANESTHESIOLOGY	180		180			53
54	RADIOLOGY-DIAGNOSTIC	672,126		672,126			54
60	LABORATORY	418,575		418,575			60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	18,604		18,604			65
66	PHYSICAL THERAPY	261,761		261,761			66
71	MEDICAL SUPPLIES CHARGED TO	71,804		71,804			71
72	IMPL. DEV. CHARGED TO PATIE	492,552		492,552			72
73	DRUGS CHARGED TO PATIENTS	305,632		305,632			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	1,369,060		1,369,060			88
88.01	RHC II	85,001		85,001			88.01
88.02	RHC III	157,421		157,421			88.02
88.03	RHC IV	494,556		494,556			88.03
88.04	RHC V	100,687		100,687			88.04
88.05	RHC VI	811,156		811,156			88.05
90	CLINIC	30,167		30,167			90
91	EMERGENCY	408,452		408,452			91
92	OBSERVATION BEDS (NON-DISTI	285,972		285,972			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	150,311		150,311			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)	7,788,588		7,788,588			200
201	LESS OBSERVATION BEDS	285,972		285,972			201
202	TOTAL (SEE INSTRUCTIONS)	7,502,616		7,502,616			202

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	717,490		717,490				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	177,026	1,074,648	1,251,674	0.444720			50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	318,583	3,033,621	3,352,204	0.200503			54
60	LABORATORY	235,523	2,250,982	2,486,505	0.168339			60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY	54,297	368,163	422,460	0.619611			66
71	MEDICAL SUPPLIES CHARGED TO	200,072	427,476	627,548	0.114420			71
72	IMPL. DEV. CHARGED TO PATIE	150,383	121,097	271,480	1.814321			72
73	DRUGS CHARGED TO PATIENTS	164,003	615,522	779,525	0.392075			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		1,261,864	1,261,864				88
88.01	RHC II		104,226	104,226				88.01
88.02	RHC III		145,969	145,969				88.02
88.03	RHC IV		452,447	452,447				88.03
88.04	RHC V		105,702	105,702				88.04
88.05	RHC VI		1,384,555	1,384,555				88.05
90	CLINIC							90
91	EMERGENCY	148,698	1,879,445	2,028,143	0.201392			91
92	OBSERVATION BEDS (NON-DISTI		339,270	339,270	0.842904			92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		178,861	178,861	0.840379			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)	2,166,075	13,743,848	15,909,923				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		13,743,848	15,909,923				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	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.444720		469,791			208,925		50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.200503		765,817			153,549		54
60	LABORATORY	0.168339		546,758			92,041		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY								65
66	PHYSICAL THERAPY	0.619611		89,989			55,758		66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.114420		200,803			22,976		71
72	IMPL. DEV. CHARGED TO PATIENTS	1.814321		48,870			88,666		72
73	DRUGS CHARGED TO PATIENTS	0.392075		197,536			77,449		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								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
88.05	RHC VI								88.05
90	CLINIC								90
91	EMERGENCY	0.201392		448,087			90,241		91
92	OBSERVATION BEDS (NON-DISTINCT	0.842904		107,344			90,481		92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.840379							95
200	SUBTOTAL (SEE INSTRUCTIONS)			2,874,995			880,086		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			2,874,995			880,086		202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.444720							50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.200503							54
60	LABORATORY	0.168339							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY								65
66	PHYSICAL THERAPY	0.619611							66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.114420							71
72	IMPL. DEV. CHARGED TO PATIENTS	1.814321							72
73	DRUGS CHARGED TO PATIENTS	0.392075							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								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
88.05	RHC VI								88.05
90	CLINIC								90
91	EMERGENCY	0.201392							91
92	OBSERVATION BEDS (NON-DISTINCT	0.842904							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.840379							95
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	140,565	23,210	117,355	359	326.89	9	2,942	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 (LINES 30-199)	140,565		117,355	359		9	2,942	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

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

	COST CENTER DESCRIPTION	CAP-REL 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	47,169	1,251,674	0.037685			50
53	ANESTHESIOLOGY	64					53
54	RADIOLOGY-DIAGNOSTIC	78,042	3,352,204	0.023281			54
60	LABORATORY	37,171	2,486,505	0.014949			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	7,044					65
66	PHYSICAL THERAPY	21,929	422,460	0.051908			66
71	MEDICAL SUPPLIES CHARGED TO P	12,514	627,548	0.019941			71
72	IMPL. DEV. CHARGED TO PATIENT	21,042	271,480	0.077508			72
73	DRUGS CHARGED TO PATIENTS	16,343	779,525	0.020965			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	74,872	1,261,864	0.059334			88
88.01	RHC II	3,631	104,226	0.034838			88.01
88.02	RHC III	6,725	145,969	0.046071			88.02
88.03	RHC IV	21,127	452,447	0.046695			88.03
88.04	RHC V	4,301	105,702	0.040690			88.04
88.05	RHC VI	34,652	1,384,555	0.025028			88.05
90	CLINIC	10,644					90
91	EMERGENCY	46,126	2,028,143	0.022743			91
92	OBSERVATION BEDS (NON-DISTINC	43,853	339,270	0.129257			92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
200	TOTAL (SUM OF LINES 50-199)	487,249	15,013,572				200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART III

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	359		9		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)	359		9		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

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

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							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
88.05	RHC VI							88.05
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES							95
200	TOTAL (SUM OF LINES 50-199)							200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS — WORKSHEET D PART IV

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
	[ ] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[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	1,251,674							50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	3,352,204							54
60	LABORATORY	2,486,505							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY								65
66	PHYSICAL THERAPY	422,460							66
71	MEDICAL SUPPLIES CHARGED TO	627,548							71
72	IMPL. DEV. CHARGED TO PATIEN	271,480							72
73	DRUGS CHARGED TO PATIENTS	779,525							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	1,261,864							88
88.01	RHC II	104,226							88.01
88.02	RHC III	145,969							88.02
88.03	RHC IV	452,447							88.03
88.04	RHC V	105,702							88.04
88.05	RHC VI	1,384,555							88.05
90	CLINIC								90
91	EMERGENCY	2,028,143							91
92	OBSERVATION BEDS (NON-DISTIN	339,270							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	178,861							95
200	TOTAL (SUM OF LINES 50-199)	15,013,572							200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS WORKSHEET D PART V

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.444720							50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.200503							54
60	LABORATORY	0.168339							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY								65
66	PHYSICAL THERAPY	0.619611							66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.114420							71
72	IMPL. DEV. CHARGED TO PATIENTS	1.814321							72
73	DRUGS CHARGED TO PATIENTS	0.392075							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								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
88.05	RHC VI								88.05
90	CLINIC								90
91	EMERGENCY	0.201392							91
92	OBSERVATION BEDS (NON-DISTINCT	0.842904							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.840379							95
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST PART I

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)	430	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	359	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	247	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	71	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	129	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)	27	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	117.40	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.40	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,097,927	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	181,286	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	916,641	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)	916,641	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

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)	2,553.32	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	329,378	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)	329,378	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					195,843	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					525,221	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)					68,940	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)					68,940	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)	112	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	2,553.32	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	285,972	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	140,565	916,641	0.153348	285,972	43,853	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST PART I

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)	430	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	359	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	247	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	71	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	9	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	117.40	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.40	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	1,097,927	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	181,286	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	916,641	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)	916,641	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK APPLICABLE BOXES
[ ] TITLE V-INPT [XX] HOSPITAL (14-1316) [ ] SUB (OTHER) [ ] PPS
[ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA
[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)	2,553.32	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	22,980	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)	22,980	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					22,980	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					2,942	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					2,942	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)	112	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

	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						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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		332,820		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.444720	74,554	33,156	50
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.200503	95,720	19,192	54
60	LABORATORY	0.168339	66,917	11,265	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY				65
66	PHYSICAL THERAPY	0.619611	5,810	3,600	66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.114420	97,295	11,132	71
72	IMPL. DEV. CHARGED TO PATIENTS	1.814321	48,923	88,762	72
73	DRUGS CHARGED TO PATIENTS	0.392075	71,935	28,204	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				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
88.05	RHC VI				88.05
90	CLINIC				90
91	EMERGENCY	0.201392	2,640	532	91
92	OBSERVATION BEDS (NON-DISTINCT	0.842904			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		463,794	195,843	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		463,794		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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.444720			50
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.200503	5,100	1,023	54
60	LABORATORY	0.168339	2,633	443	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY				65
66	PHYSICAL THERAPY	0.619611	12,632	7,827	66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.114420	1,116	128	71
72	IMPL. DEV. CHARGED TO PATIENTS	1.814321			72
73	DRUGS CHARGED TO PATIENTS	0.392075	4,774	1,872	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				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
88.05	RHC VI				88.05
90	CLINIC				90
91	EMERGENCY	0.201392			91
92	OBSERVATION BEDS (NON-DISTINCT	0.842904			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		26,255	11,293	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		26,255		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 TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.444720			50
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.200503			54
60	LABORATORY	0.168339			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY				65
66	PHYSICAL THERAPY	0.619611			66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.114420			71
72	IMPL. DEV. CHARGED TO PATIENTS	1.814321			72
73	DRUGS CHARGED TO PATIENTS	0.392075			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				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
88.05	RHC VI				88.05
90	CLINIC				90
91	EMERGENCY	0.201392			91
92	OBSERVATION BEDS (NON-DISTINCT	0.842904			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	880,086	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (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)	880,086	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	888,887	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)	952	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	465,356	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	422,579	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)	422,579	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	422,579	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)	63,723	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	48,429	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	63,723	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	471,008	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	471,008	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	9,420	40.01
41	INTERIM PAYMENTS	368,539	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	93,049	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	12,567	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 APPLICABLE BOX: [XX] HOSPITAL (14-1316) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				233,583		275,553	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.				7,183		92,986	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		NONE		NONE	3.01
			.02					3.02
		PROGRAM TO PROVIDER	.03					3.03
			.04					3.04
			.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50		NONE		NONE	3.50
			.51					3.51
		PROVIDER TO PROGRAM	.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					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)				240,766		368,539	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
		PROGRAM TO PROVIDER	.02					5.02
			.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER TO PROGRAM	.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	PROGRAM TO PROVIDER	.01		260,723		102,469	6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				501,489		471,008	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)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				39,101			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		NONE		NONE	3.01
		.02					3.02
	PROGRAM	.03					3.03
	TO	.04					3.04
	PROVIDER	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50	03/12/2010	7,392		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		-7,392			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)				31,709			4
TO BE COMPLETED BY CONTRACTOR							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE		NONE	5.01
	TO	.02					5.02
	PROVIDER	.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER	.50		NONE		NONE	5.50
	TO	.51					5.51
	PROGRAM	.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
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	PROGRAM TO PROVIDER	.01		49,326			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				81,035			7

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT WORKSHEET E-1
PART II

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

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	107	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	129	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	247	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	15,909,923	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	599,997	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	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 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	69,629		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)	11,406		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	27		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)	81,035		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	81,035		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)			11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	81,035		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)			13
14	80% OF PART B COSTS (LINE 12 x 80%)			14
15	SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	81,035		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)	81,035		19
19.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	1,621		19.01
20	INTERIM PAYMENTS	31,709		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	47,705		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	525,221	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	525,221	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	530,473	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)	530,473	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	30,784	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	499,689	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	499,689	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	2,368	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	1,800	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	2,368	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	501,489	28
29	OTHER ADJUSTMENTS (LOSS ON SALE OF ASSETS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	501,489	30
30.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	10,030	30.01
31	INTERIM PAYMENTS	240,766	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS LINES 30.01, 31 AND 32)	250,693	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	7,501	34

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	22,980		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	22,980		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	22,980		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)	22,980		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	22,980		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)	22,980		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)	22,980		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38	SUBTOTAL (LINE 36 ± LINE 37)	22,980		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)	22,980		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	22,980		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,682,596				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	19,309,514				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-13,070,013				6
7	INVENTORY					7
8	PREPAID EXPENSES	158,421				8
9	OTHER CURRENT ASSETS	755,074				9
10	DUE FROM OTHER FUNDS	5,064,379				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	14,899,971				11
	FIXED ASSETS					
12	LAND	97,500				12
13	LAND IMPROVEMENTS	1,015,106				13
14	ACCUMULATED DEPRECIATION	-76,786				14
15	BUILDINGS	10,220,514				15
16	ACCUMULATED DEPRECIATION	-739,458				16
17	LEASEHOLD IMPROVEMENTS	25,227				17
18	ACCUMULATED AMORTIZATION	-2,132				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	6,830,916				23
24	ACCUMULATED DEPRECIATION	-1,194,304				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)	16,176,583				30
	OTHER ASSETS					
31	INVESTMENTS	3,630,404				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	40,354				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	3,670,758				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	34,747,312				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	206,035				37
38	SALARIES, WAGES & FEES PAYABLE	1,106,281				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	19,153,672				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	20,465,988				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	10,805,638				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)	10,805,638				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	31,271,626				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	3,475,686				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)	3,475,686				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	34,747,312				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD	4,776,511								1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	-1,300,825								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	3,475,686								3
4	ADDITIONS (CREDIT ADJUST-MENTS)									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)	3,475,686								11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									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)	3,475,686								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	714,910		714,910	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	714,910		714,910	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)	714,910		714,910	17
18	ANCILLARY SERVICES	1,465,381	11,751,079	13,216,460	18
19	OUTPATIENT SERVICES		1,384,555	1,384,555	19
20	RHC		984,890	984,890	20
20.01	RHC II		104,226	104,226	20.01
20.02	RHC III		145,969	145,969	20.02
20.03	RHC IV		452,447	452,447	20.03
20.04	RHC V		105,702	105,702	20.04
20.05	RHC VI				20.05
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	2,180,291	14,928,868	17,109,159	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		7,854,832	29
30	ADD (SPECIFY)			30
31				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)		7,854,832	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	17,109,159	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	10,944,041	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	6,165,118	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	7,854,832	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,689,714	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	12,047	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)	-113	24.01
24.02	OTHER (UNREALIZED GAINS)	4,205	24.02
24.03	OTHER (GRANTS)		24.03
24.04	OTHER (CATERING)		24.04
24.05	OTHER (LOSS ON DISPOSAL)	-228	24.05
24.06	OTHER (COUNTY TERRACE)		24.06
24.07	OTHER (NET OTHER INCOME)	372,978	24.07
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	388,889	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,300,825	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)	-1,300,825	29

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES WORKSHEET L-1
PART I

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS 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
	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
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
88.05	RHC VI						88.05
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL 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						202
	LINES 190-201)						
203	TOTAL STATISTICAL BASIS						203
204	UNIT COST MULTIPLIER						204
204	UNIT COST MULTIPLIER						204

RHC I WORKSHEET M-1

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

COMPONENT NO: 14-3448

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	633,218	289,981	923,199	-33,170	890,029	-66,685	823,344	9
10	SUBTOTAL (SUM OF LINES 1-9)	633,218	289,981	923,199	-33,170	890,029	-66,685	823,344	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	PROFESSINAL 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)	633,218	289,981	923,199	-33,170	890,029	-66,685	823,344	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)	633,218	289,981	923,199	-33,170	890,029	-66,685	823,344	32

RHC I WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3448

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.55	1,411	4,200	2,310		1
2	PHYSICIAN ASSISTANTS	0.84	4,322	2,100	1,764		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	1.39	5,733		4,074	5,733	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.39	5,733			5,733	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)	823,344	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)	823,344	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)	545,716	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	545,716	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	545,716	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	545,716	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,369,060	20

RHC I WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3448

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	1,369,060	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	256,920	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,112,140	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	5,733	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,733	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	193.99	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	(SEE INSTR.) 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)	193.99	193.99	193.99	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	991			10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	192,244			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)		192,244		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%)		152,191		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		152,191		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		2,005		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		32,681		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		152,191		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		79,965		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		232,156		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		2,124		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1,614		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		12		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		233,770		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		4,675		26.01
27	INTERIM PAYMENTS		121,590		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		107,505		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		3,287		30

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

RHC I WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-3448

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	823,344	823,344	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.004900	0.080000	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	4,034	65,868	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	4,813	79,795	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	8,847	145,663	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	823,344	823,344	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	545,716	545,716	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.010745	0.176916	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	5,864	96,546	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	14,711	242,209	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	216	8,373	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	68.11	28.93	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	68	2,604	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	4,631	75,334	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)		256,920	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)		79,965	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	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				121,590	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		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		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			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				121,590	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 PROVIDER	.01		112,180	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				233,770	7

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

RHC II WORKSHEET M-1

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

COMPONENT NO: 14-3485

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	50,413	13,427	63,840		63,840		63,840	9
10	SUBTOTAL (SUM OF LINES 1-9)	50,413	13,427	63,840		63,840		63,840	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	PROFESSINAL 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)	50,413	13,427	63,840		63,840		63,840	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)	50,413	13,427	63,840		63,840		63,840	32

RHC II WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3485

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS			4,200			1
2	PHYSICIAN ASSISTANTS	0.23	501	2,100	483		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	0.23	501		483	501	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.23	501			501	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)	63,840	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)	63,840	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)	21,161	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	21,161	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	21,161	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	21,161	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	85,001	20

RHC II WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3485

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	85,001	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	21,899	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	63,102	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	501	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	501	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	125.95	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (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)	125.95	125.95	125.95	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	124		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	15,618		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)		15,618	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%)		12,277	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		12,277	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		272	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		3,339	19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		12,277	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		9,654	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		21,931	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		1	23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1	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)		21,932	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		439	26.01
27	INTERIM PAYMENTS		13,754	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		7,739	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		311	30

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

RHC II WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-3485

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	63,840	63,840	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.003400	0.093000	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	217	5,937	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	362	9,931	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	579	15,868	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	63,840	63,840	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	21,161	21,161	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.009070	0.248559	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	192	5,260	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	771	21,128	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	38	1,042	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	20.29	20.28	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	474	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	41	9,613	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)		21,899	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)		9,654	16

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

RHC II COMPONENT NO: 14-3485

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				13,754	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		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		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			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				13,754	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 PROVIDER	.01		8,178	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				21,932	7

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

RHC III WORKSHEET M-1

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

COMPONENT NO: 14-3496

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	87,765	30,580	118,345		118,345		118,345	9
10	SUBTOTAL (SUM OF LINES 1-9)	87,765	30,580	118,345		118,345		118,345	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	PROFESSINAL 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)	87,765	30,580	118,345		118,345		118,345	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)	87,765	30,580	118,345		118,345		118,345	32

RHC III WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3496

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS			4,200			1
2	PHYSICIAN ASSISTANTS	0.42	1,053	2,100	882		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	0.42	1,053		882	1,053	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.42	1,053			1,053	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)	118,345	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)	118,345	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)	39,076	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	39,076	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	39,076	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	39,076	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	157,421	20

RHC III WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3496

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	157,421	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	61,025	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	96,396	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	1,053	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	1,053	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	91.54	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	(SEE INSTR.) 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)	91.54	91.54	91.54	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	238		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	21,787		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)		21,787	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%)		16,581	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		16,581	16.05
17	PRIMARY PAYOR PAYMENTS			17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		1,061	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		5,601	19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		16,581	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		22,946	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		39,527	22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		1	23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1	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)		39,528	26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		791	26.01
27	INTERIM PAYMENTS		15,711	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		23,026	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		574	30

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

RHC III WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-3496

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	118,345	118,345	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.002400	0.182000	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	284	21,539	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	315	23,739	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	599	45,278	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	118,345	118,345	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	39,076	39,076	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.005061	0.382593	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	198	14,950	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	797	60,228	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	33	2,491	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	24.15	24.18	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	16	933	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	386	22,560	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)		61,025	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)		22,946	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	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				15,711	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		NONE	3.01
			.02			3.02
		PROGRAM TO PROVIDER	.03			3.03
			.04			3.04
			.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		NONE	3.50
			.51			3.51
		PROVIDER TO PROGRAM	.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			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				15,711	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.		.01		NONE	5.01
			.02			5.02
		PROGRAM TO PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER TO PROGRAM	.50		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 (SEE INSTR.	PROGRAM TO PROVIDER	.01		23,817	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				39,528	7

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

RHC IV WORKSHEET M-1

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

COMPONENT NO: 14-8521

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	261,595	123,493	385,088	-13,009	372,079		372,079	9
10	SUBTOTAL (SUM OF LINES 1-9)	261,595	123,493	385,088	-13,009	372,079		372,079	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	PROFESSINAL 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)	261,595	123,493	385,088	-13,009	372,079		372,079	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)	261,595	123,493	385,088	-13,009	372,079		372,079	32

RHC IV WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-8521

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.25		4,200	1,050		1
2	PHYSICIAN ASSISTANTS	0.45	1,605	2,100	945		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	0.70	1,605		1,995	1,995	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.70	1,605			1,995	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)	372,079	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)	372,079	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)	122,477	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	122,477	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	122,477	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	122,477	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	494,556	20

RHC IV WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-8521

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	494,556	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	97,700	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	396,856	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	1,995	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	1,995	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	198.93	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	(SEE INSTR.) 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)	198.93	198.93	198.93	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	820			10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	163,123			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)		163,123		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%)		129,390		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		129,390		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		1,385		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		22,623		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		129,390		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		66,025		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		195,415		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		1		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1		23.01
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		11		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (SEE INSTRUCTIONS)		195,416		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		3,908		26.01
27	INTERIM PAYMENTS		144,456		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		47,052		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		2,779		30

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

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC IV
COMPONENT NO: 14-8521

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	372,079	372,079	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000700	0.084000	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	260	31,255	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	343	41,646	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	603	72,901	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	372,079	372,079	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	122,477	122,477	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001621	0.195929	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	199	23,997	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	802	96,898	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	36	4,370	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	22.28	22.17	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	25	2,953	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	557	65,468	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)		97,700	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)		66,025	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	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				144,456	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		NONE	3.01
			.02			3.02
		PROGRAM TO PROVIDER	.03			3.03
			.04			3.04
			.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		NONE	3.50
			.51			3.51
		PROVIDER TO PROGRAM	.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			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				144,456	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.		.01		NONE	5.01
			.02			5.02
		PROGRAM TO PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER TO PROGRAM	.50		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 (SEE INSTR.	PROGRAM TO PROVIDER	.01		50,960	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				195,416	7

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

RHC V WORKSHEET M-1

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

COMPONENT NO: 14-8526

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	47,845	28,016	75,861		75,861		75,861	9
10	SUBTOTAL (SUM OF LINES 1-9)	47,845	28,016	75,861		75,861		75,861	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	PROFESSINAL 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)	47,845	28,016	75,861		75,861		75,861	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)	47,845	28,016	75,861		75,861		75,861	32

RHC V WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-8526

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS			4,200			1
2	PHYSICIAN ASSISTANTS	0.35	566	2,100	735		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	0.35	566		735	735	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.35	566			735	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)	75,861	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)	75,861	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)	24,826	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	24,826	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	24,826	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	24,826	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	100,687	20

RHC V WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-8526

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	100,687	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	41,925	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	58,762	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	735	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	735	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	79.95	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	(SEE INSTR.) 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)	79.95	79.95	79.95	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	118			10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	9,434			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)		9,434		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%)		7,547		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		7,547		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR				18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		7,547		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		10,768		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		18,315		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		35		23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		27		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)		18,342		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		367		26.01
27	INTERIM PAYMENTS		5,900		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		12,075		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		259		30

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

RHC V WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-8526

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	75,861	75,861	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.003300	0.168000	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	250	12,745	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	353	18,240	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	603	30,985	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	75,861	75,861	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	24,826	24,826	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.007949	0.408444	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	197	10,140	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	800	41,125	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	37	1,914	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	21.62	21.49	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	8	493	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	173	10,595	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)		41,925	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		10,768	16

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

RHC V COMPONENT NO: 14-8526

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				5,900	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		NONE	3.01
			.02			3.02
		PROGRAM TO PROVIDER	.03			3.03
			.04			3.04
			.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		NONE	3.50
			.51			3.51
		PROVIDER TO PROGRAM	.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			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				5,900	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.		.01		NONE	5.01
			.02			5.02
		PROGRAM TO PROVIDER	.03			5.03
			.04			5.04
			.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
		PROVIDER TO PROGRAM	.50		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 (SEE INSTR.	PROGRAM TO PROVIDER	.01		12,442	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				18,342	7

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

RHC VI WORKSHEET M-1

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

COMPONENT NO: 14-8531

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	284,673	405,240	689,913	-48	689,865	-76,680	613,185	9
10	SUBTOTAL (SUM OF LINES 1-9)	284,673	405,240	689,913	-48	689,865	-76,680	613,185	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	PROFESSINAL 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)	284,673	405,240	689,913	-48	689,865	-76,680	613,185	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)	284,673	405,240	689,913	-48	689,865	-76,680	613,185	32

RHC VI WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-8531

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.83	3,304	4,200	3,486		1
2	PHYSICIAN ASSISTANTS	0.99	2,342	2,100	2,079		2
3	NURSE PRACTITIONERS			2,100			3
4	SUBTOTAL (SUM OF LINES 1-3)	1.82	5,646		5,565	5,646	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.82	5,646			5,646	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)	613,185	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)	613,185	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)	197,971	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	197,971	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	197,971	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	197,971	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	811,156	20

RHC VI WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-8531

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	811,156	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	11,660	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	799,496	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	5,646	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,646	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	141.60	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	(SEE INSTR.) 3	
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 100-04, CHAPTER 9, §20.6 OR YOUR CONTRACTOR)	200.00			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	141.60	141.60	141.60	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,126			10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	159,442			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)		159,442		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%)		127,554		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		127,554		16.05
17	PRIMARY PAYOR PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR				18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)				19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		127,554		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		3,007		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		130,561		22
23	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)				23
23.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)				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)		130,561		26
26.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		2,611		26.01
27	INTERIM PAYMENTS		56,300		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 26.01, 27 AND 28)		71,650		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, CHAPTER I, SECTION 115.2		1,851		30

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

RHC VI WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-8531

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	613,185	613,185	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000400	0.006900	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	245	4,231	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	841	3,497	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,086	7,728	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	613,185	613,185	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	197,971	197,971	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001771	0.012603	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	351	2,495	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,437	10,223	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	21	367	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	68.43	27.86	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	13	76	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	890	2,117	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)		11,660	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)		3,007	16

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

RHC VI COMPONENT NO: 14-8531

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				56,300	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		NONE	3.01
			.02			3.02
		PROGRAM	.03			3.03
		TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.50		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			3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				56,300	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 PROVIDER	.01		74,261	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				130,561	7

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