

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/28/2012 4:17 pm
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Date: 3/28/2012 Time: 4:17 pm

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: 4
 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 WERE 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 BCC DBA ILLINI COMMUNITY HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 3/28/2012 Time: 4:17 pm
 2mrHikW5amX4dFMJdi6MbZAJskatw0
 r6Uwr0gVcZgZ3w3sncBVGVENSvH5Kn
 ILOH0NgI6D05YWPz
 PI: Date: 3/28/2012 Time: 4:17 pm
 Mrc.xqGhOZZ2:dfs1cbkK5qs0gwdp0
 ODMTZ0wFGIthry1rszWmtS7.PEfgDc
 UjKCAHS:U20qMaAw

(Signed)

 officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		Title XIX 5.00	Total
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	145,500	-142,747	1,022,172	0
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	66,099	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 SKILLED NURSING FACILITY	0	0	0	0	0
8.00 NURSING FACILITY	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	-1,231	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	211,599	-143,978	1,022,172	0

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**Blessing Care Corporation
d/b/a Illini Community Hospital
Protested item
September 30, 2011**

We believe that the Illinois Provider Tax is an allowable cost under Medicare cost reimbursement principles. We understand that National Government Services does not share this view. The expense is therefore included as a protested item. The reimbursement effect of including this \$94,128 of provider tax is to increase reimbursement by approximately \$50,000.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/28/2012 4:05 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date:	Time:
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. <input type="checkbox"/> Initial Report for this Provider CCN	12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. <input type="checkbox"/> Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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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 BCC DBA ILLINI COMMUNITY HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
officer or Administrator of Provider(s)

Title _____

Date _____

Cost Center Description	Title V 1.00	Title XVIII		Title 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	163,696	-115,306	1,022,172	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	69,655	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	218	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	233,351	-115,088	1,022,172	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

118,263

Difference
\$50,642

ADJUSTMENTS TO EXPENSES

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8

Date/Time Prepared:
3/28/2012 4:06 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
				Cost Center	Line #
				1.00	2.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)	B	-32,129	INTEREST EXPENSE	113.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-1,297,066		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-179,683		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-2,799	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	B	-2,169	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-317,393	CAP REL COSTS-MVBLE EQUIP	2.00 32.00
33.00	MISCELLANEOUS INCOME	B	-5,553	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01	MISCELLANEOUS HOUSEKEEPING INCOME	B	-19	HOUSEKEEPING	9.00 33.01
33.02	MISCELLANEOUS RADIOLOGY INCOME	B	-968	RADIOLOGY-DIAGNOSTIC	54.00 33.02
33.03	MISCELLANEOUS BENEFITS INCOME	B	-2,209	EMPLOYEE BENEFITS	4.00 33.03
33.04	MISCELLANEOUS SUPPLIES REVENUE	B	-570	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 33.04
33.05	PHYSICIAN RECRUITMENT	A	-31,028	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06	CABLE TELEVISION	A	-2,553	OPERATION OF PLANT	7.00 33.06
33.07	MISCELLANEOUS EXPENSE	A	-25,063	ADMINISTRATIVE & GENERAL	5.00 33.07
33.08	PUBLIC RELATIONS SALARIES	A	-21,932	ADMINISTRATIVE & GENERAL	5.00 33.08
33.09	PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-6,927	EMPLOYEE BENEFITS	4.00 33.09
33.10	PUBLIC RELATIONS EXPENSES	A	-76,668	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11	COFFEE SHOP RECEIPTS	B	-45,566	DIETARY	10.00 33.11
33.12	MEALS ON WHEELS	B	-4,778	DIETARY	10.00 33.12
33.13	LOBBYING EXPENSE	B	-8,815	ADMINISTRATIVE & GENERAL	5.00 33.13
33.14	NON-RHC PHYSICIAN COST	A	-44,596	RURAL HEALTH CLINIC	88.00 33.14
33.15	PROVIDER TAX	A	94,128	ADMINISTRATIVE & GENERAL	5.00 33.15
33.16			0		0.00 33.16
33.17			0		0.00 33.17
33.18			0		0.00 33.18
33.19			0		0.00 33.19
33.20			0		0.00 33.20

Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8 Date/Time Prepared: 3/28/2012 4:06 pm
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #
			Cost Center	Line #	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)	1.00	-2,014,356	3.00	4.00	50.00

Cost Center	Description	Wkst. A-7 Ref.	5.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	0	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	0	24.00
25.00	Utilization review - physicians' compensation (chapter 21)	0	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist	0	28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	0	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	0	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	9	32.00
33.00	MISCELLANEOUS INCOME	0	33.00
33.01	MISCELLANEOUS HOUSEKEEPING INCOME	0	33.01
33.02	MISCELLANEOUS RADIOLOGY INCOME	0	33.02
33.03	MISCELLANEOUS BENEFITS INCOME	0	33.03
33.04	MISCELLANEOUS SUPPLIES REVENUE	0	33.04
33.05	PHYSICIAN RECRUITMENT	0	33.05
33.06	CABLE TELEVISION	0	33.06
33.07	MISCELLANEOUS EXPENSE	0	33.07
33.08	PUBLIC RELATIONS SALARIES	0	33.08
33.09	PUBLIC RELATIONS EMPLOYEE BENEFITS	0	33.09
33.10	PUBLIC RELATIONS EXPENSES	0	33.10
33.11	COFFEE SHOP RECEIPTS	0	33.11
33.12	MEALS ON WHEELS	0	33.12
33.13	LOBBYING EXPENSE	0	33.13
33.14	NON-RHC PHYSICIAN COST	0	33.14
33.15	PROVIDER TAX	0	33.15
33.16		0	33.16
33.17		0	33.17
33.18		0	33.18
33.19		0	33.19
33.20		0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-2
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 640 WEST WASHINGTON	PO Box:		Zip Code: 62363		County: PIKE			1.00	
2.00	City: PITTSFIELD	State: IL							2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	I	09/01/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	BCC DBA ILLINI COMM HOSP-SWINGBED	142315	99914		09/01/2001	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTG									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BCC DBA ILLINI COMM HOSP-RHC	143482	99914		07/03/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2010	09/30/2011		20.00	
21.00	Type of Control (see instructions)					2				21.00
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					0				23.00
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		25.00	
						1.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.									2 26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.									2 27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.									0 35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/28/2012 4:10 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	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.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	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				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	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)		0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00			62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	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				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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)		0.00	0.00	0.000000	64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

worksheet S-2
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in 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)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	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)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in 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)		0.00	0.00	0.000000	67.00
						1.00 2.00 3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) 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. (see instructions)				0	71.00
						1.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) 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. (see instructions)				0	76.00
						1.00
80.00	Long Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N		80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/28/2012 4:10 pm	
					1.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N		86.00
					V XIX 1.00 2.00
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	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	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	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	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 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. (see instructions)		N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(C). Enter "Y" for yes or "N" for no.		Y		108.00
					Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00
109.00	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 no for each therapy.		Y	N	109.00
					1.00 2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	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.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		1,500,000	5,500,000	119.00
120.00	Is this a SCH or EACH that qualifies for the outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/28/2012 4:10 pm		
			1.00		2.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	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. (see instructions)					140.00
			Y		14H132	
			1.00		2.00	
	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.					
141.00	Name: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131		141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:				142.00
143.00	City: QUINCY	State: IL	Zip Code:	62301		143.00
					1.00	
144.00	Are provider based physicians' costs included in worksheet A?					144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					145.00
					Y	
					N	
					1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "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.					146.00
					N	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					147.00
					N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					148.00
					N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					149.00
					N	
					Part A	
					1.00	
					Part B	
					2.00	
155.00	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)					155.00
156.00	Hospital				N	155.00
157.00	Subprovider - IPF				N	156.00
158.00	Subprovider - IRF				N	157.00
159.00	SUBPROVIDER				N	158.00
160.00	SNF				N	159.00
161.00	HOME HEALTH AGENCY				N	160.00
	CMHC				N	161.00
					1.00	
165.00	Multicampus 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.					165.00
					N	
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
						FTE/Campus
						5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					166.00
						0.00
						1.00
167.00	Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00
						Y
						1,022,172
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					169.00
						0.00

		Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation				
1.00	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		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	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		2.00
3.00	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		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	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.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			11.00
		Y/N 1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description 0	Y/N 1.00	Date 2.00
PS&R Data				
16.00	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)	N		16.00
17.00	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)	Y	02/29/2012	17.00
18.00	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 this cost report? If yes, see instructions.	N		18.00
19.00	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		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

		Part A		
Description		Y/N	Date	
0		1.00	2.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	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	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	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.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	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)	N		16.00
17.00	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)	Y	02/29/2012	17.00
18.00	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 this cost report? If yes, see instructions.	N		18.00
19.00	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		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Available		
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	53,952.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	53,952.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		25	9,125	53,952.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,849	141	2,239	1.00	
2.00 HMO		28	0		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	426	0	426	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		18	18	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,275	159	2,683	7.00	
8.00 INTENSIVE CARE UNIT					8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY					13.00	
14.00 Total (see instructions)	0	2,275	159	2,683	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC	0	2,301	0	9,805	26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	111	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				9	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	459	1.00
2.00 HMO					6	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	161.09	0.00	0	459	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	8.45	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	169.54	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

worksheet S-3
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	48	592		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	48	592		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141315 Component CCN: 143482	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/28/2012 4:10 pm
			Rural Health Clinic (RHC) I	Cost
				1.00
1.00	Clinic Address and Identification			
	Street	321 WEST WASHINGTON		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County		PITTSFIELD IL 62363	
				1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00
			Grant Award	Date
			1.00	2.00
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			0 4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0 5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0 6.00
7.00	Appalachian Regional Commission			0 7.00
8.00	Look-Alikes			0 8.00
9.00	OTHER (SPECIFY)			0 9.00
				1.00 2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N 0 10.00
		Sunday		Monday
		from	to	from
		1.00	2.00	3.00
				4.00
11.00	Facility hours of operations (1)			
	Clinic	07:00 17:30		11.00
				1.00 2.00
12.00	Have you received an approval for an exception to the productivity standard?			N 12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N 0 13.00
			Provider name	CCN number
			1.00	2.00
14.00	Provider name, CCN number			
		Y/N	V	XVIII
		1.00	2.00	3.00
				4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)			N 0 0 0 15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141315 Component CCN: 143482	Period: From 10/01/2010 To 09/30/2011	worksheet S-8 Date/Time Prepared: 3/28/2012 4:10 pm
		Rural Health Clinic (RHC) I	Cost

		County				
		4.00				
2.00	City, State, Zip Code, County	PIKE				2.00
		Tuesday		Wednesday		
		from	to	from	to	
		5.00	6.00	7.00	8.00	
11.00	Facility hours of operations (1) Clinic	07:00	17:30	07:00	17:30	11.00

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

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2010
To 09/30/2011

worksheet S-8
Date/Time Prepared:
3/28/2012 4:10 pm

		Thursday		Friday		Cost
		from	to	from	to	
Facility hours of operations (1)		9:00	10:00	11:00	12:00	
11.00	Clinic	07:00	17:30	07:00	17:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141315 Component CCN:143482	Period: From 10/01/2010 To 09/30/2011	worksheet S-8 Date/Time Prepared: 3/28/2012 4:10 pm
		Rural Health Clinic (RHC) I	Cost

		Saturday		
		from	to	
		13,00	14,00	
11.00	Facility hours of operations (1) Clinic	07:00	12:00	11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-10

Date/Time Prepared:
3/28/2012 4:10 pm

		1.00			
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.411861	1.00		
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	1,269,136	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	347,527	5.00		
6.00	Medicaid charges	7,085,421	6.00		
7.00	Medicaid cost (line 1 times line 6)	2,918,209	7.00		
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,301,546	8.00		
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP	0	9.00		
10.00	Stand-alone SCHIP charges	0	10.00		
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00		
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00		
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00		
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00		
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00		
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00		
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00		
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00		
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,301,546	19.00		
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	524,786	628,813	1,153,599 20.00	
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	216,139	258,984	475,123 21.00	
22.00	Partial payment by patients approved for charity care	3,290	6,368	9,658 22.00	
23.00	Cost of charity care (line 21 minus line 22)	212,849	252,616	465,465 23.00	
				1.00	
24.00	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		24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0		25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,360,048		26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)	628,801		27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,731,247		28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	713,033		29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,178,498		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,480,044		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT		456,066	456,066	118,401	574,467	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		670,535	670,535	5,733	676,268	2.00
3.00	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	2,316,314	2,316,314	0	2,316,314	4.00
5.00	ADMINISTRATIVE & GENERAL	1,040,698	1,571,456	2,612,154	14,391	2,626,545	5.00
6.00	MAINTENANCE & REPAIRS	303,553	173,674	477,227	0	477,227	6.00
7.00	OPERATION OF PLANT	0	323,897	323,897	78,426	402,323	7.00
8.00	LAUNDRY & LINEN SERVICE	0	90,132	90,132	0	90,132	8.00
9.00	HOUSEKEEPING	274,771	39,265	314,036	0	314,036	9.00
10.00	DIETARY	185,949	120,778	306,727	0	306,727	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	200,787	54,187	254,974	-103,117	151,857	13.00
16.00	MEDICAL RECORDS & LIBRARY	92,159	165,447	257,606	0	257,606	16.00
17.00	SOCIAL SERVICE	0	0	0	52,755	52,755	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	280,999	280,999	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,280,346	71,880	1,352,226	-53,457	1,298,769	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	452,066	144,887	596,953	680	597,633	50.00
53.00	ANESTHESIOLOGY	280,999	2,973	283,972	-283,972	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	671,772	799,110	1,470,882	-6	1,470,876	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	31,449	127,396	158,845	-32,661	126,184	54.01
60.00	LABORATORY	467,999	620,089	1,088,088	-86,963	1,001,125	60.00
65.00	RESPIRATORY THERAPY	161,649	59,184	220,833	-22,141	198,692	65.00
65.01	SLEEP STUDIES	36,132	9,919	46,051	-90	45,961	65.01
66.00	PHYSICAL THERAPY	136,111	123,592	259,703	-31,500	228,203	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,985	167,700	208,685	146,903	355,588	71.00
73.00	DRUGS CHARGED TO PATIENTS	321,395	1,963,934	2,285,329	-1,157	2,284,172	73.00
73.01	ONCOLOGY	99,396	264,805	364,201	-31	364,170	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	385,803	718,938	1,104,741	-282	1,104,459	88.00
91.00	EMERGENCY	701,530	1,564,640	2,266,170	-381	2,265,789	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE		114,463	114,463	-82,334	32,129	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,165,549	12,735,261	19,900,810	196	19,901,006	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	108,499	5,642	114,141	-196	113,945	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	AUTOMATED HEALTH SERVICES	0	62	62	0	62	193.01
193.02	RENAL	0	0	0	0	0	193.02
193.03	LEASED SPACE	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	0	0	0	193.04
193.05	WELLNESS	60,175	6,497	66,672	0	66,672	193.05
200.00	TOTAL (SUM OF LINES 118-199)	7,334,223	12,747,462	20,081,685	0	20,081,685	200.00

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	574,467	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-317,393	358,875	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	-508,658	1,807,656	4.00
5.00	ADMINISTRATIVE & GENERAL	200,089	2,826,634	5.00
6.00	MAINTENANCE & REPAIRS	0	477,227	6.00
7.00	OPERATION OF PLANT	-2,553	399,770	7.00
8.00	LAUNDRY & LINEN SERVICE	4,354	94,486	8.00
9.00	HOUSEKEEPING	-19	314,017	9.00
10.00	DIETARY	-51,158	255,569	10.00
11.00	CAFETERIA	0	0	11.00
13.00	NURSING ADMINISTRATION	0	151,857	13.00
16.00	MEDICAL RECORDS & LIBRARY	10,475	268,081	16.00
17.00	SOCIAL SERVICE	0	52,755	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	280,999	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,298,769	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	597,633	50.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-14,314	1,456,562	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	0	126,184	54.01
60.00	LABORATORY	0	1,001,125	60.00
65.00	RESPIRATORY THERAPY	0	198,692	65.00
65.01	SLEEP STUDIES	0	45,961	65.01
66.00	PHYSICAL THERAPY	0	228,203	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-570	355,018	71.00
73.00	DRUGS CHARGED TO PATIENTS	24,082	2,308,254	73.00
73.01	ONCOLOGY	-250,500	113,670	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-64,340	1,040,119	88.00
91.00	EMERGENCY	-1,105,850	1,159,939	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	-32,129	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,108,484	17,792,522	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	113,945	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	AUTOMATED HEALTH SERVICES	0	62	193.01
193.02	RENAL	0	0	193.02
193.03	LEASED SPACE	0	0	193.03
193.04	UNUSED SPACE	0	0	193.04
193.05	WELLNESS	0	66,672	193.05
200.00	TOTAL (SUM OF LINES 118-199)	-2,108,484	17,973,201	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	10,300	1.00
	TOTALS		0	10,300	
B - RECLASS UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	78,426	1.00
	TOTALS		0	78,426	
C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	146,903	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	146,903	
D - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	81,483	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	851	2.00
	TOTALS		0	82,334	
E - RECLASS SOCIAL SERVICE SALARY					
1.00	SOCIAL SERVICE	17.00	52,755	0	1.00
	TOTALS		52,755	0	
F - RECLASS MISCELLANEOUS ANESTH EXPENSE					
1.00	OPERATING ROOM	50.00	0	2,973	1.00
	TOTALS		0	2,973	
G - RECLASS DIRECTOR OF PATIENT CARE SAL					
1.00	NURSING ADMINISTRATION	13.00	7,945	0	1.00
	TOTALS		7,945	0	
H - RECLASS CRNA COSTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	280,999	0	1.00
	TOTALS		280,999	0	
I - RECLASS UR COORDINATOR SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	30,426	0	1.00
	TOTALS		30,426	0	
J - RECLASS NURSING MANAGER SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	80,636	0	1.00
	TOTALS		80,636	0	
K - RECLASS BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,500	1.00
	TOTALS		0	31,500	
500.00	Grand Total: Increases		452,761	352,436	500.00

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

worksheet A-6

Date/Time Prepared:
3/28/2012 4:10 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,300	0		1.00
	TOTALS		0	10,300			
B - RECLASS UTILITIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	78,426	0		1.00
	TOTALS		0	78,426			
C - RECLASS MEDICAL SUPPLIES EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	0	702	0		1.00
2.00	OPERATING ROOM	50.00	0	2,293	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6	0		3.00
4.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	32,661	0		4.00
5.00	LABORATORY	60.00	0	86,963	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	22,141	0		6.00
7.00	SLEEP STUDIES	65.01	0	90	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,157	0		8.00
9.00	ONCOLOGY	73.01	0	31	0		9.00
10.00	EMERGENCY	91.00	0	381	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	282	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	196	0		12.00
	TOTALS		0	146,903			
D - RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	82,334	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	82,334			
E - RECLASS SOCIAL SERVICE SALARY							
1.00	ADULTS & PEDIATRICS	30.00	52,755	0	0		1.00
	TOTALS		52,755	0			
F - RECLASS MISCELLANEOUS ANESTH EXPENSE							
1.00	ANESTHESIOLOGY	53.00	0	2,973	0		1.00
	TOTALS		0	2,973			
G - RECLASS DIRECTOR OF PATIENT CARE SAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	7,945	0	0		1.00
	TOTALS		7,945	0			
H - RECLASS CRNA COSTS							
1.00	ANESTHESIOLOGY	53.00	280,999	0	0		1.00
	TOTALS		280,999	0			
I - RECLASS UR COORDINATOR SALARY							
1.00	NURSING ADMINISTRATION	13.00	30,426	0	0		1.00
	TOTALS		30,426	0			
J - RECLASS NURSING MANAGER SALARY							
1.00	NURSING ADMINISTRATION	13.00	80,636	0	0		1.00
	TOTALS		80,636	0			
K - RECLASS BUILDING RENT							
1.00	PHYSICAL THERAPY	66.00	0	31,500	10		1.00
	TOTALS		0	31,500			
500.00	Grand Total: Decreases		452,761	352,436			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/28/2012 4:10 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	134,251	0	0	0	0
2.00	Land Improvements	258,001	0	0	0	0
3.00	Buildings and Fixtures	6,448,376	0	0	0	0
4.00	Building Improvements	855,178	0	0	0	0
5.00	Fixed Equipment	0	0	0	0	0
6.00	Movable Equipment	5,596,086	985,479	0	985,479	0
7.00	HIT designated Assets	0	0	0	0	0
8.00	Subtotal (sum of lines 1-7)	13,291,892	985,479	0	985,479	0
9.00	Reconciling Items	0	0	0	0	0
10.00	Total (line 8 minus line 9)	13,291,892	985,479	0	985,479	0
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	456,066	0	0	0	0
2.00	CAP REL COSTS-MVBLE EQUIP	670,535	0	0	0	0
3.00	Total (sum of lines 1-2)	1,126,601	0	0	0	0
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,303,555	0	7,303,555	0.525999	5,418
2.00	CAP REL COSTS-MVBLE EQUIP	6,581,565	0	6,581,565	0.474001	4,882
3.00	Total (sum of lines 1-2)	13,885,120	0	13,885,120	1.000000	10,300

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/28/2012 4:10 pm

		Ending Balance	Fully depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	134,251	0			1.00
2.00	Land Improvements	258,001	0			2.00
3.00	Buildings and Fixtures	6,448,376	0			3.00
4.00	Building Improvements	855,178	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	6,581,565	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	14,277,371	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	14,277,371	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	456,066			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	670,535			2.00
3.00	Total (sum of lines 1-2)	0	1,126,601			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	5,418	456,066	31,500
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	4,882	353,142	0
3.00	Total (sum of lines 1-2)	0	0	10,300	809,208	31,500

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description		SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
		11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	81,483	5,418	0	0	574,467	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	851	4,882	0	0	358,875	2.00	
3.00	Total (sum of lines 1-2)	82,334	10,300	0	0	933,342	3.00	

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			
			Cost Center	Line #		
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)	B	-32,129		INTEREST EXPENSE	113.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	7.00
8.00 Television and radio service (chapter 21)		0			0.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,297,066				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-179,683				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-2,799		DIETARY	10.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts	B	-2,169		MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines		0			0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0		CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0		CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist		0		NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00 Physicians' assistant		0			0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-317,393		CAP REL COSTS-MVBLE EQUIP	2.00	32.00
33.00 MISCELLANEOUS INCOME	B	-5,553		ADMINISTRATIVE & GENERAL	5.00	33.00
33.01 MISCELLANEOUS HOUSEKEEPING INCOME	B	-19		HOUSEKEEPING	9.00	33.01
33.02 MISCELLANEOUS RADIOLOGY INCOME	B	-968		RADIOLOGY-DIAGNOSTIC	54.00	33.02
33.03 MISCELLANEOUS BENEFITS INCOME	B	-2,209		EMPLOYEE BENEFITS	4.00	33.03
33.04 MISCELLANEOUS SUPPLIES REVENUE	B	-570		MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	33.04
33.05 PHYSICIAN RECRUITMENT	A	-31,028		ADMINISTRATIVE & GENERAL	5.00	33.05
33.06 CABLE TELEVISION	A	-2,553		OPERATION OF PLANT	7.00	33.06
33.07 MISCELLANEOUS EXPENSE	A	-25,063		ADMINISTRATIVE & GENERAL	5.00	33.07
33.08 PUBLIC RELATIONS SALARIES	A	-21,932		ADMINISTRATIVE & GENERAL	5.00	33.08
33.09 PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-6,927		EMPLOYEE BENEFITS	4.00	33.09
33.10 PUBLIC RELATIONS EXPENSES	A	-76,668		ADMINISTRATIVE & GENERAL	5.00	33.10
33.11 COFFEE SHOP RECEIPTS	B	-45,566		DIETARY	10.00	33.11
33.12 MEALS ON WHEELS	B	-4,778		DIETARY	10.00	33.12
33.13 LOBBYING EXPENSE	B	-8,815		ADMINISTRATIVE & GENERAL	5.00	33.13
33.14 NON-RHC PHYSICIAN COST	A	-44,596		RURAL HEALTH CLINIC	88.00	33.14
33.15		0			0.00	33.15
33.16		0			0.00	33.16
33.17		0			0.00	33.17
33.18		0			0.00	33.18
33.19		0			0.00	33.19
33.20		0			0.00	33.20

Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8 Date/Time Prepared: 3/28/2012 4:10 pm
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Cost Center Description		Basis/Code (Z)	Amount	Cost Center	Line #
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	1.00	-2,108,484	3.00	4.00

Expense Classification on Worksheet A
 to/from which the amount is to be adjusted

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 Vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00 Non-physician Anesthetist		28.00
29.00 Physicians' assistant	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	9	32.00
33.00 MISCELLANEOUS INCOME	0	33.00
33.01 MISCELLANEOUS HOUSEKEEPING INCOME	0	33.01
33.02 MISCELLANEOUS RADIOLOGY INCOME	0	33.02
33.03 MISCELLANEOUS BENEFITS INCOME	0	33.03
33.04 MISCELLANEOUS SUPPLIES REVENUE	0	33.04
33.05 PHYSICIAN RECRUITMENT	0	33.05
33.06 CABLE TELEVISION	0	33.06
33.07 MISCELLANEOUS EXPENSE	0	33.07
33.08 PUBLIC RELATIONS SALARIES	0	33.08
33.09 PUBLIC RELATIONS EMPLOYEE BENEFITS	0	33.09
33.10 PUBLIC RELATIONS EXPENSES	0	33.10
33.11 COFFEE SHOP RECEIPTS	0	33.11
33.12 MEALS ON WHEELS	0	33.12
33.13 LOBBYING EXPENSE	0	33.13
33.14 NON-RHC PHYSICIAN COST	0	33.14
33.15	0	33.15
33.16	0	33.16
33.17	0	33.17
33.18	0	33.18
33.19	0	33.19
33.20	0	33.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 141315

Period: From 10/01/2010 To 09/30/2011

Worksheet A-8-1

Date/Time Prepared: 3/28/2012 4:10 pm

	Line No.		Expense Items		
	1.00	2.00			3.00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1.00
2.00		10.00	DIETARY	DIETICIAN	2.00
3.00		8.00	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	3.00
4.00		4.00	EMPLOYEE BENEFITS	HEALTH INSURANCE	4.00
4.01		88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	4.01
4.02		91.00	EMERGENCY	ER PHYSICIANS	4.02
4.03		88.00	RURAL HEALTH CLINIC	RHC CLINIC BUILDING	4.03
4.04		5.00	ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS	4.04
4.05		16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	4.05
4.06		54.00	RADIOLOGY-DIAGNOSTIC	ECHO SERVICES	4.06
4.07		73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
6.00		B	0.00	6.00
7.00		G	0.00	7.00
8.00		G	0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER	0.00	100.00

(1) Use the following symbols to indicate 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.

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

Provider CCN: 141315

Period: From 10/01/2010 To 09/30/2011

worksheet A-8-1

Date/Time Prepared: 3/28/2012 4:10 pm

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	793,675	438,535	355,140	0	1.00
2.00	17,445	15,460	1,985	0	2.00
3.00	72,274	67,920	4,354	0	3.00
4.00	950,722	1,450,244	-499,522	0	4.00
4.01	464,442	474,003	-9,561	0	4.01
4.02	1,435,550	1,494,834	-59,284	0	4.02
4.03	8,073	18,256	-10,183	0	4.03
4.04	45,000	30,992	14,008	0	4.04
4.05	62,671	50,027	12,644	0	4.05
4.06	5,399	18,745	-13,346	0	4.06
4.07	54,082	30,000	24,082	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	3,909,333	4,089,016	-179,683	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

related organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	BLESSING CORP S	0.00	HOME OFFICE	6.00
7.00	BLESSING HOSP	0.00	HOSPITAL	7.00
8.00	DENMAN SERVICES	0.00	LAUNDRY	8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

(1) Use the following symbols to indicate 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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
3/28/2012 4:10 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	60.00	LABORATORY	28,627	0	1.00
2.00	73.01	ONCOLOGY	250,500	250,500	2.00
3.00	91.00	EMERGENCY	1,448,534	1,046,566	3.00
4.00	13.00	UM REVIEW	2,300	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,729,961	1,297,066	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

worksheet A-8-2

Date/Time Prepared:
3/28/2012 4:10 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	28,627	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	401,968	0	0	0	0	3.00
4.00	2,300	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	432,895					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
3/28/2012 4:10 pm

	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
3/28/2012 4:10 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	0	1.00
2.00	0	250,500	2.00
3.00	0	1,046,566	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	1,297,066	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 3/28/2012 4:10 pm
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		Physical Therapy					Cost
							1.00
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						27 1.00
2.00	Line 1 multiplied by 15 hours per week						405 2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						59 3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						30 4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0 5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0 6.00
7.00	Standard travel expense rate						3.45 7.00
8.00	Optional travel expense rate per mile						0.00 8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	155.43	90.30	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.49	55.12	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.75	36.75	27.56			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
PART II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0 14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						11,423 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						4,977 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						16,400 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0 18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0 19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						16,400 20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						66.74 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						27,030 22.00
23.00	Total salary equivalency (see instructions)						27,030 23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						2,168 24.00
25.00	Assistants (line 4 times column 3, line 11)						827 25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						2,995 26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						307 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						3,302 28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0 29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0 30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0 31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0 32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0 35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0 36.00
37.00	Assistants (line 6 times column 3, line 11)						0 37.00
38.00	Subtotal (sum of lines 36 and 37)						0 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0 39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0 41.00
42.00	Subtotal (sum of lines 40 and 41)						0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0 43.00
Total Travel Allowance and Travel Expense - offsite services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0 45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY PROVIDER CCN: 141315
 OUTSIDE SUPPLIERS

Period:
 From 10/01/2010
 To 09/30/2011

Worksheet A-8-3 Par
 Date/Time Prepared:
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		Physical Therapy				Cost
						1.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0 46.00
		Therapists	Assistants	Aides	Trainees	Total
		1.00	2.00	3.00	4.00	5.00
PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00 47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00 48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00 49.00
CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00 50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00 51.00
DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.49	55.12	0.00	0.00	0.00 52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0 53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0 54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0 55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0 56.00
						1.00
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57.00	Salary equivalency amount (from line 23)					27,030 57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0 58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0 59.00
60.00	Overtime allowance (from column 5, line 56)					0 60.00
61.00	Equipment cost (see instructions)					0 61.00
62.00	Supplies (see instructions)					0 62.00
63.00	Total allowance (sum of lines 57-62)					27,030 63.00
64.00	Total cost of outside supplier services (from your records)					12,376 64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0 65.00
LINE 33 CALCULATION						
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					2,995 100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					307 100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					3,302 100.02
LINE 34 CALCULATION						
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					307 101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0 101.01
101.02	Line 34 = sum of lines 27 and 31					307 101.02
LINE 35 CALCULATION						
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0 102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0 102.01
102.02	Line 35 = sum of lines 31 and 32					0 102.02

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	574,467	574,467			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	358,875		358,875		2.00
4.00	EMPLOYEE BENEFITS	1,807,656	0	0	1,807,656	4.00
5.00	ADMINISTRATIVE & GENERAL	2,826,634	107,545	75,863	277,338	5.00
6.00	MAINTENANCE & REPAIRS	477,227	113,912	80,356	75,041	6.00
7.00	OPERATION OF PLANT	399,770	0	0	0	7.00
8.00	LAUNDRY & LINEN SERVICE	94,486	0	0	0	8.00
9.00	HOUSEKEEPING	314,017	8,746	6,169	67,926	9.00
10.00	DIETARY	255,569	10,672	7,528	45,968	10.00
11.00	CAFETERIA	0	3,858	2,721	0	11.00
13.00	NURSING ADMINISTRATION	151,857	992	700	24,145	13.00
16.00	MEDICAL RECORDS & LIBRARY	268,081	17,304	12,206	22,782	16.00
17.00	SOCIAL SERVICE	52,755	689	486	13,041	17.00
19.00	NONPHYSICIAN ANESTHETISTS	280,999	0	0	69,465	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,298,769	54,782	38,643	303,471	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	597,633	33,688	23,764	111,754	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,456,562	23,410	16,514	166,067	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	126,184	2,490	1,756	7,774	54.01
60.00	LABORATORY	1,001,125	11,881	8,381	115,693	60.00
65.00	RESPIRATORY THERAPY	198,692	6,400	4,515	39,961	65.00
65.01	SLEEP STUDIES	45,961	1,811	1,277	8,932	65.01
66.00	PHYSICAL THERAPY	228,203	10,523	7,423	33,648	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	355,018	7,253	5,116	10,132	71.00
73.00	DRUGS CHARGED TO PATIENTS	2,308,254	7,946	5,605	79,451	73.00
73.01	ONCOLOGY	113,670	5,591	3,944	24,571	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,040,119	0	11,812	95,374	88.00
91.00	EMERGENCY	1,159,939	29,531	20,832	173,424	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,792,522	459,024	335,611	1,765,958	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,708	2,616	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	113,945	15,050	10,616	26,822	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	AUTOMATED HEALTH SERVICES	62	0	0	0	193.01
193.02	RENAL	0	11,091	0	0	193.02
193.03	LEASED SPACE	0	28,101	0	0	193.03
193.04	UNUSED SPACE	0	43,271	0	0	193.04
193.05	WELLNESS	66,672	14,222	10,032	14,876	193.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	17,973,201	574,467	358,875	1,807,656	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	3,287,380					5.00
6.00	MAINTENANCE & REPAIRS	167,110	913,646				6.00
7.00	OPERATION OF PLANT	89,487	0	489,257			7.00
8.00	LAUNDRY & LINEN SERVICE	21,150	0	0	115,636		8.00
9.00	HOUSEKEEPING	88,835	24,475	12,501	0	522,669	9.00
10.00	DIETARY	71,572	29,865	15,254	0	19,216	10.00
11.00	CAFETERIA	1,473	10,795	5,514	0	6,946	11.00
13.00	NURSING ADMINISTRATION	39,776	2,776	1,418	0	1,786	13.00
16.00	MEDICAL RECORDS & LIBRARY	71,715	48,424	24,733	0	31,157	16.00
17.00	SOCIAL SERVICE	14,991	1,927	984	0	1,240	17.00
19.00	NONPHYSICIAN ANESTHETISTS	78,450	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	379,570	153,305	78,303	115,636	98,641	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	171,655	94,273	48,152	0	60,658	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	372,158	65,513	33,462	0	42,153	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	30,937	6,968	3,559	0	4,483	54.01
60.00	LABORATORY	254,532	33,248	16,982	0	21,393	60.00
65.00	RESPIRATORY THERAPY	55,865	17,911	9,149	0	11,525	65.00
65.01	SLEEP STUDIES	12,979	5,067	2,588	0	3,261	65.01
66.00	PHYSICAL THERAPY	62,632	29,448	15,041	0	18,948	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,506	20,297	10,367	0	13,060	71.00
73.00	DRUGS CHARGED TO PATIENTS	537,516	22,237	11,358	0	14,308	73.00
73.01	ONCOLOGY	33,079	15,647	7,992	0	10,068	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	256,821	46,860	0	0	0	88.00
91.00	EMERGENCY	309,743	82,642	42,211	0	53,175	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,206,552	711,678	339,568	115,636	412,018	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,416	10,377	5,301	0	6,677	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	37,256	42,116	21,512	0	27,099	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	AUTOMATED HEALTH SERVICES	14	0	0	0	0	193.01
193.02	RENAL	2,483	31,038	15,853	0	19,971	193.02
193.03	LEASED SPACE	6,290	78,639	24,844	0	31,296	193.03
193.04	UNUSED SPACE	9,686	0	61,851	0	0	193.04
193.05	WELLNESS	23,683	39,798	20,328	0	25,608	193.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,287,380	913,646	489,257	115,636	522,669	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	455,644					10.00
11.00 CAFETERIA	0	31,307				11.00
13.00 NURSING ADMINISTRATION	0	564	224,014			13.00
16.00 MEDICAL RECORDS & LIBRARY	0	532	12	496,946		16.00
17.00 SOCIAL SERVICE	0	304	0	0	86,417	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	1,621	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	455,644	7,084	91,031	34,646	86,417	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	2,608	33,412	30,169	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	1,936	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	3,876	163	132,574	0	54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	0	181	3,239	16,306	0	54.01
60.00 LABORATORY	0	2,700	21	85,265	0	60.00
65.00 RESPIRATORY THERAPY	0	933	7,995	20,405	0	65.00
65.01 SLEEP STUDIES	0	208	0	6,332	0	65.01
66.00 PHYSICAL THERAPY	0	785	0	13,204	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	236	0	15,827	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,854	0	71,891	0	73.00
73.01 ONCOLOGY	0	574	9,678	3,520	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	2,226	15,494	0	0	88.00
91.00 EMERGENCY	0	4,048	55,502	64,871	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	455,644	30,334	216,547	496,946	86,417	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	626	7,467	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02 RENAL	0	0	0	0	0	193.02
193.03 LEASED SPACE	0	0	0	0	0	193.03
193.04 UNUSED SPACE	0	0	0	0	0	193.04
193.05 WELLNESS	0	347	0	0	0	193.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	455,644	31,307	224,014	496,946	86,417	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
6.00	MAINTENANCE & REPAIRS				6.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
13.00	NURSING ADMINISTRATION				13.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
17.00	SOCIAL SERVICE				17.00
19.00	NONPHYSICIAN ANESTHETISTS	430,535			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	3,195,942	0	3,195,942
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	1,207,766	0	1,207,766
53.00	ANESTHESIOLOGY	430,535	432,471	0	432,471
54.00	RADIOLOGY-DIAGNOSTIC	0	2,312,452	0	2,312,452
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	0	203,877	0	203,877
60.00	LABORATORY	0	1,551,221	0	1,551,221
65.00	RESPIRATORY THERAPY	0	373,351	0	373,351
65.01	SLEEP STUDIES	0	88,416	0	88,416
66.00	PHYSICAL THERAPY	0	419,855	0	419,855
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	521,812	0	521,812
73.00	DRUGS CHARGED TO PATIENTS	0	3,060,420	0	3,060,420
73.01	ONCOLOGY	0	228,334	0	228,334
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	1,468,706	0	1,468,706
91.00	EMERGENCY	0	1,995,918	0	1,995,918
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	430,535	17,060,541	0	17,060,541
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,095	0	30,095
192.00	PHYSICIANS' PRIVATE OFFICES	0	302,509	0	302,509
193.00	NONPAID WORKERS	0	0	0	0
193.01	AUTOMATED HEALTH SERVICES	0	76	0	76
193.02	RENAL	0	80,436	0	80,436
193.03	LEASED SPACE	0	169,170	0	169,170
193.04	UNUSED SPACE	0	114,808	0	114,808
193.05	WELLNESS	0	215,566	0	215,566
200.00	Cross Foot Adjustments	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118-201)	430,535	17,973,201	0	17,973,201

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		BLDG & FIXT	MVBLE EQUIP		
	0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS					
1.00					1.00
2.00					2.00
4.00					4.00
5.00	0	0	0	0	0
6.00	0	107,545	75,863	183,408	0
7.00	0	113,912	80,356	194,268	0
8.00	0	0	0	0	0
9.00	0	8,746	6,169	14,915	0
10.00	0	10,672	7,528	18,200	0
11.00	0	3,858	2,721	6,579	0
13.00	0	992	700	1,692	0
16.00	0	17,304	12,206	29,510	0
17.00	0	689	486	1,175	0
19.00	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	0	54,782	38,643	93,425	0
ANCILLARY SERVICE COST CENTERS					
50.00	0	33,688	23,764	57,452	0
53.00	0	0	0	0	0
54.00	0	23,410	16,514	39,924	0
54.01	0	2,490	1,756	4,246	0
60.00	0	11,881	8,381	20,262	0
65.00	0	6,400	4,515	10,915	0
65.01	0	1,811	1,277	3,088	0
66.00	0	10,523	7,423	17,946	0
71.00	0	7,253	5,116	12,369	0
73.00	0	7,946	5,605	13,551	0
73.01	0	5,591	3,944	9,535	0
OUTPATIENT SERVICE COST CENTERS					
88.00	0	0	11,812	11,812	0
91.00	0	29,531	20,832	50,363	0
92.00				0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	0	0	0	0	0
118.00	0	459,024	335,611	794,635	0
NONREIMBURSABLE COST CENTERS					
190.00	0	3,708	2,616	6,324	0
192.00	0	15,050	10,616	25,666	0
193.00	0	0	0	0	0
193.01	0	0	0	0	0
193.02	0	11,091	0	11,091	0
193.03	0	28,101	0	28,101	0
193.04	0	43,271	0	43,271	0
193.05	0	14,222	10,032	24,254	0
200.00				0	200.00
201.00		0	0	0	0
202.00	0	574,467	358,875	933,342	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	183,408					5.00
6.00	MAINTENANCE & REPAIRS	9,323	203,591				6.00
7.00	OPERATION OF PLANT	4,993	0	4,993			7.00
8.00	LAUNDRY & LINEN SERVICE	1,180	0	0	1,180		8.00
9.00	HOUSEKEEPING	4,956	5,454	128	0	25,453	9.00
10.00	DIETARY	3,993	6,655	156	0	936	10.00
11.00	CAFETERIA	82	2,406	56	0	338	11.00
13.00	NURSING ADMINISTRATION	2,219	619	14	0	87	13.00
16.00	MEDICAL RECORDS & LIBRARY	4,001	10,790	252	0	1,517	16.00
17.00	SOCIAL SERVICE	836	429	10	0	60	17.00
19.00	NONPHYSICIAN ANESTHETISTS	4,377	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	21,177	34,162	801	1,180	4,803	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	9,577	21,007	491	0	2,954	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	20,764	14,598	341	0	2,053	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	1,726	1,553	36	0	218	54.01
60.00	LABORATORY	14,201	7,409	173	0	1,042	60.00
65.00	RESPIRATORY THERAPY	3,117	3,991	93	0	561	65.00
65.01	SLEEP STUDIES	724	1,129	26	0	159	65.01
66.00	PHYSICAL THERAPY	3,494	6,562	153	0	923	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,715	4,523	106	0	636	71.00
73.00	DRUGS CHARGED TO PATIENTS	29,987	4,955	116	0	697	73.00
73.01	ONCOLOGY	1,846	3,487	82	0	490	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	14,329	10,442	0	0	0	88.00
91.00	EMERGENCY	17,281	18,415	431	0	2,590	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	178,898	158,586	3,465	1,180	20,064	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	79	2,312	54	0	325	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,079	9,385	220	0	1,320	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	AUTOMATED HEALTH SERVICES	1	0	0	0	0	193.01
193.02	RENAL	139	6,916	162	0	973	193.02
193.03	LEASED SPACE	351	17,524	254	0	1,524	193.03
193.04	UNUSED SPACE	540	0	631	0	0	193.04
193.05	WELLNESS	1,321	8,868	207	0	1,247	193.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	183,408	203,591	4,993	1,180	25,453	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	29,940					10.00
11.00 CAFETERIA	0	9,461				11.00
13.00 NURSING ADMINISTRATION	0	170	4,801			13.00
16.00 MEDICAL RECORDS & LIBRARY	0	161	0	46,231		16.00
17.00 SOCIAL SERVICE	0	92	0	0	2,602	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	490	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	29,940	2,140	1,953	3,224	2,602	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	788	716	2,808	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	180	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,172	3	12,322	0	54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	0	55	69	1,517	0	54.01
60.00 LABORATORY	0	816	0	7,935	0	60.00
65.00 RESPIRATORY THERAPY	0	282	171	1,899	0	65.00
65.01 SLEEP STUDIES	0	63	0	589	0	65.01
66.00 PHYSICAL THERAPY	0	237	0	1,229	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71	0	1,473	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	561	0	6,690	0	73.00
73.01 ONCOLOGY	0	173	207	328	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	673	332	0	0	88.00
91.00 EMERGENCY	0	1,223	1,190	6,037	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	29,940	9,167	4,641	46,231	2,602	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	189	160	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02 RENAL	0	0	0	0	0	193.02
193.03 LEASED SPACE	0	0	0	0	0	193.03
193.04 UNUSED SPACE	0	0	0	0	0	193.04
193.05 WELLNESS	0	105	0	0	0	193.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	29,940	9,461	4,801	46,231	2,602	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
19.00	NONPHYSICIAN ANESTHETISTS	4,867				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		195,407	0	195,407	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		95,793	0	95,793	50.00
53.00	ANESTHESIOLOGY		180	0	180	53.00
54.00	RADIOLOGY-DIAGNOSTIC		91,177	0	91,177	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC		9,420	0	9,420	54.01
60.00	LABORATORY		51,838	0	51,838	60.00
65.00	RESPIRATORY THERAPY		21,029	0	21,029	65.00
65.01	SLEEP STUDIES		5,778	0	5,778	65.01
66.00	PHYSICAL THERAPY		30,544	0	30,544	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		23,893	0	23,893	71.00
73.00	DRUGS CHARGED TO PATIENTS		56,557	0	56,557	73.00
73.01	ONCOLOGY		16,148	0	16,148	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		37,588	0	37,588	88.00
91.00	EMERGENCY		97,530	0	97,530	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	732,882	0	732,882	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,094	0	9,094	190.00
192.00	PHYSICIANS' PRIVATE OFFICES		39,019	0	39,019	192.00
193.00	NONPAID WORKERS		0	0	0	193.00
193.01	AUTOMATED HEALTH SERVICES		1	0	1	193.01
193.02	RENAL		19,281	0	19,281	193.02
193.03	LEASED SPACE		47,754	0	47,754	193.03
193.04	UNUSED SPACE		44,442	0	44,442	193.04
193.05	WELLNESS		36,002	0	36,002	193.05
200.00	Cross Foot Adjustments	4,867	4,867	0	4,867	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,867	933,342	0	933,342	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQ. FEET)	MVBLE EQUIP (SQ. FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	119,284						1.00
2.00		105,638					2.00
4.00	0	0	7,312,291				4.00
5.00	22,331	22,331	1,121,883	-3,287,380		14,685,821	5.00
6.00	23,653	23,653	303,553	0		746,536	6.00
7.00	0	0	0	0		399,770	7.00
8.00	0	0	0	0		94,486	8.00
9.00	1,816	1,816	274,771	0		396,858	9.00
10.00	2,216	2,216	185,949	0		319,737	10.00
11.00	801	801	0	0		6,579	11.00
13.00	206	206	97,670	0		177,694	13.00
16.00	3,593	3,593	92,159	0		320,373	16.00
17.00	143	143	52,755	0		66,971	17.00
19.00	0	0	280,999	0		350,464	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	11,375	11,375	1,227,591	0		1,695,665	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	6,995	6,995	452,066	0		766,839	50.00
53.00	0	0	0	0		0	53.00
54.00	4,861	4,861	671,772	0		1,662,553	54.00
54.01	517	517	31,449	0		138,204	54.01
60.00	2,467	2,467	467,999	0		1,137,080	60.00
65.00	1,329	1,329	161,649	0		249,568	65.00
65.01	376	376	36,132	0		57,981	65.01
66.00	2,185	2,185	136,111	0		279,797	66.00
71.00	1,506	1,506	40,985	0		377,519	71.00
73.00	1,650	1,650	321,395	0		2,401,256	73.00
73.01	1,161	1,161	99,396	0		147,776	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	0	3,477	385,803	0		1,147,305	88.00
91.00	6,132	6,132	701,530	0		1,383,726	91.00
92.00							92.00
SPECIAL PURPOSE COST CENTERS							
113.00	0	0	0	0		0	113.00
118.00	95,313	98,790	7,143,617	-3,287,380		14,324,737	118.00
NONREIMBURSABLE COST CENTERS							
190.00	770	770	0	0		6,324	190.00
192.00	3,125	3,125	108,499	0		166,433	192.00
193.00	0	0	0	0		0	193.00
193.01	0	0	0	0		62	193.01
193.02	2,303	0	0	0		11,091	193.02
193.03	5,835	0	0	0		28,101	193.03
193.04	8,985	0	0	0		43,271	193.04
193.05	2,953	2,953	60,175	0		105,802	193.05
200.00							200.00
201.00							201.00
202.00	574,467	358,875	1,807,656			3,287,380	202.00
203.00	4.815960	3.397215	0.247208			0.223847	203.00
204.00			0			183,408	204.00
205.00			0.000000			0.012489	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

worksheet B-1

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
6.00	67,792					6.00
7.00	0	71,074				7.00
8.00	0	0	2,719			8.00
9.00	1,816	1,816	0	60,273		9.00
10.00	2,216	2,216	0	2,216	2,719	10.00
11.00	801	801	0	801	0	11.00
13.00	206	206	0	206	0	13.00
16.00	3,593	3,593	0	3,593	0	16.00
17.00	143	143	0	143	0	17.00
19.00	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	11,375	11,375	2,719	11,375	2,719	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	6,995	6,995	0	6,995	0	50.00
53.00	0	0	0	0	0	53.00
54.00	4,861	4,861	0	4,861	0	54.00
54.01	517	517	0	517	0	54.01
60.00	2,467	2,467	0	2,467	0	60.00
65.00	1,329	1,329	0	1,329	0	65.00
65.01	376	376	0	376	0	65.01
66.00	2,185	2,185	0	2,185	0	66.00
71.00	1,506	1,506	0	1,506	0	71.00
73.00	1,650	1,650	0	1,650	0	73.00
73.01	1,161	1,161	0	1,161	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	3,477	0	0	0	0	88.00
91.00	6,132	6,132	0	6,132	0	91.00
92.00						92.00
SPECIAL PURPOSE COST CENTERS						
113.00	0	0	0	0	0	113.00
118.00	52,806	49,329	2,719	47,513	2,719	118.00
NONREIMBURSABLE COST CENTERS						
190.00	770	770	0	770	0	190.00
192.00	3,125	3,125	0	3,125	0	192.00
193.00	0	0	0	0	0	193.00
193.01	0	0	0	0	0	193.01
193.02	2,303	2,303	0	2,303	0	193.02
193.03	5,835	3,609	0	3,609	0	193.03
193.04	0	8,985	0	0	0	193.04
193.05	2,953	2,953	0	2,953	0	193.05
200.00						200.00
201.00						201.00
202.00	913,646	489,257	115,636	522,669	455,644	202.00
203.00	13,477,195	6,883,769	42,528,871	8,671,694	167,577,786	203.00
204.00	203,591	4,993	1,180	25,453	29,940	204.00
205.00	3.003171	0.070251	0.433983	0.422295	11.011401	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description		CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	5,426,135					11.00
13.00	NURSING ADMINISTRATION	97,670	2,158,134				13.00
16.00	MEDICAL RECORDS & LIBRARY	92,159	117	40,321,181			16.00
17.00	SOCIAL SERVICE	52,755	0	0	2,719		17.00
19.00	NONPHYSICIAN ANESTHETISTS	280,999	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,227,591	876,984	2,811,043	2,719		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	452,066	321,887	2,447,792	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	157,073	0	100	53.00
54.00	RADIOLOGY-DIAGNOSTIC	671,772	1,571	10,757,498	0	0	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	31,449	31,205	1,322,969	0	0	54.01
60.00	LABORATORY	467,999	205	6,918,078	0	0	60.00
65.00	RESPIRATORY THERAPY	161,649	77,027	1,655,606	0	0	65.00
65.01	SLEEP STUDIES	36,132	0	513,787	0	0	65.01
66.00	PHYSICAL THERAPY	136,111	0	1,071,356	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,985	0	1,284,108	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	321,395	0	5,832,911	0	0	73.00
73.01	ONCOLOGY	99,396	93,236	285,572	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	385,803	149,265	0	0	0	88.00
91.00	EMERGENCY	701,530	534,705	5,263,388	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,257,461	2,086,202	40,321,181	2,719	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	108,499	71,932	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	RENAL	0	0	0	0	0	193.02
193.03	LEASED SPACE	0	0	0	0	0	193.03
193.04	UNUSED SPACE	0	0	0	0	0	193.04
193.05	WELLNESS	60,175	0	0	0	0	193.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	31,307	224,014	496,946	86,417	430,535	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.005770	0.103800	0.012325	31.782641	4,305.350000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	9,461	4,801	46,231	2,602	4,867	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001744	0.002225	0.001147	0.956969	48.670000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Total Cost (From Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Total Costs
			Total Costs	Costs		Total Costs	
				RCE	Disallowance		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	3,195,942		3,195,942	0	0		30.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	1,207,766		1,207,766	0	0		50.00
53.00 ANESTHESIOLOGY	432,471		432,471	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,312,452		2,312,452	0	0		54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	203,877		203,877	0	0		54.01
60.00 LABORATORY	1,551,221		1,551,221	0	0		60.00
65.00 RESPIRATORY THERAPY	373,351	0	373,351	0	0		65.00
65.01 SLEEP STUDIES	88,416	0	88,416	0	0		65.01
66.00 PHYSICAL THERAPY	419,855	0	419,855	0	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	521,812		521,812	0	0		71.00
73.00 DRUGS CHARGED TO PATIENTS	3,060,420		3,060,420	0	0		73.00
73.01 ONCOLOGY	228,334		228,334	0	0		73.01
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	1,468,706		1,468,706	0	0		88.00
91.00 EMERGENCY	1,995,918		1,995,918	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	127,724		127,724	0	0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00 INTEREST EXPENSE							113.00
200.00 Subtotal (see instructions)	17,188,265	0	17,188,265	0	0		200.00
201.00 Less Observation Beds	127,724		127,724	0	0		201.00
202.00 Total (see instructions)	17,060,541	0	17,060,541	0	0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Charges			Hospital Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,665,357		2,665,357			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	212,962	2,234,830	2,447,792	0.493410	0.000000	50.00
53.00 ANESTHESIOLOGY	49,481	107,592	157,073	2.753312	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	741,215	10,016,283	10,757,498	0.214962	0.000000	54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	5,587	1,317,382	1,322,969	0.154106	0.000000	54.01
60.00 LABORATORY	917,817	6,000,261	6,918,078	0.224227	0.000000	60.00
65.00 RESPIRATORY THERAPY	625,648	1,029,958	1,655,606	0.225507	0.000000	65.00
65.01 SLEEP STUDIES	0	513,787	513,787	0.172087	0.000000	65.01
66.00 PHYSICAL THERAPY	140,263	931,093	1,071,356	0.391891	0.000000	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	677,409	606,699	1,284,108	0.406361	0.000000	71.00
73.00 DRUGS CHARGED TO PATIENTS	1,450,901	4,382,010	5,832,911	0.524681	0.000000	73.00
73.01 ONCOLOGY	1,635	283,937	285,572	0.799567	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	1,411,946	1,411,946			88.00
91.00 EMERGENCY	54,086	5,209,302	5,263,388	0.379208	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	145,686	145,686	0.876707	0.000000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	7,542,361	34,190,766	41,733,127			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	7,542,361	34,190,766	41,733,127			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000			54.01
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
65.01	SLEEP STUDIES	0.000000			65.01
66.00	PHYSICAL THERAPY	0.000000			66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part II
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Capital Related Cost (From Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Title XVIII		Capital Costs (column 3 x column 4)
				Hospital Inpatient Program Charges	Hospital Cost	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	95,793	2,447,792	0.039134	151,507	5,929	50.00
53.00 ANESTHESIOLOGY	180	157,073	0.001146	31,314	36	53.00
54.00 RADIOLOGY-DIAGNOSTIC	91,177	10,757,498	0.008476	576,569	4,887	54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	9,420	1,322,969	0.007120	3,636	26	54.01
60.00 LABORATORY	51,838	6,918,078	0.007493	710,083	5,321	60.00
65.00 RESPIRATORY THERAPY	21,029	1,655,606	0.012702	475,178	6,036	65.00
65.01 SLEEP STUDIES	5,778	513,787	0.011246	0	0	65.01
66.00 PHYSICAL THERAPY	30,544	1,071,356	0.028510	84,812	2,418	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	23,893	1,284,108	0.018607	538,069	10,012	71.00
73.00 DRUGS CHARGED TO PATIENTS	56,557	5,832,911	0.009696	966,706	9,373	73.00
73.01 ONCOLOGY	16,148	285,572	0.056546	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	37,588	1,411,946	0.026621	0	0	88.00
91.00 EMERGENCY	97,530	5,263,388	0.018530	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	145,686	0.000000	0	0	92.00
200.00 Total (lines 50-199)	537,475	39,067,770		3,537,874	44,038	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

worksheet D
Part IV
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Title XVIII				Hospital	Total Cost (sum of col 1 through col. 4)	Cost
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	430,535	0	0	0	430,535	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	430,535	0	0	0	430,535	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Title XVIII Hospital					
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (From Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	2,447,792	0.000000	0.000000	151,507	50.00
53.00 ANESTHESIOLOGY	0	157,073	2.740987	0.000000	31,314	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	10,757,498	0.000000	0.000000	576,569	54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	0	1,322,969	0.000000	0.000000	3,636	54.01
60.00 LABORATORY	0	6,918,078	0.000000	0.000000	710,083	60.00
65.00 RESPIRATORY THERAPY	0	1,655,606	0.000000	0.000000	475,178	65.00
65.01 SLEEP STUDIES	0	513,787	0.000000	0.000000	0	65.01
66.00 PHYSICAL THERAPY	0	1,071,356	0.000000	0.000000	84,812	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,284,108	0.000000	0.000000	538,069	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	5,832,911	0.000000	0.000000	966,706	73.00
73.01 ONCOLOGY	0	285,572	0.000000	0.000000	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	1,411,946	0.000000	0.000000	0	88.00
91.00 EMERGENCY	0	5,263,388	0.000000	0.000000	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	145,686	0.000000	0.000000	0	92.00
200.00 Total (Lines 50-199)	0	39,067,770			3,537,874	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Title XVIII			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	85,831	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01 SLEEP STUDIES	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	85,831	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description		Title XVIII		Hospital	Cost
		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0		50.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
65.01	SLEEP STUDIES	0	0		65.01
66.00	PHYSICAL THERAPY	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0		88.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part V
Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Hospital		Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost		
				Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.493410	0	1,247,052	0		50.00
53.00 ANESTHESIOLOGY	2.753312	0	54,533	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.214962	0	4,161,046	0		54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	0.154106	0	890,363	0		54.01
60.00 LABORATORY	0.224227	0	2,698,201	0		60.00
65.00 RESPIRATORY THERAPY	0.225507	0	620,491	0		65.00
65.01 SLEEP STUDIES	0.172087	0	264,867	0		65.01
66.00 PHYSICAL THERAPY	0.391891	0	335,263	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406361	0	313,990	0		71.00
73.00 DRUGS CHARGED TO PATIENTS	0.524681	0	2,737,604	3,614		73.00
73.01 ONCOLOGY	0.799567	0	153,524	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0.000000					88.00
91.00 EMERGENCY	0.379208	0	1,849,654	2,353		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.876707	0	89,572	0		92.00
200.00 Subtotal (see instructions)		0	15,416,160	5,967		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	15,416,160	5,967		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part V
Date/Time Prepared:
3/28/2012 4:10 pm

		Title XVIII			Hospital	Cost
Cost Center Description		Costs				
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	615,308	0		50.00
53.00	ANESTHESIOLOGY	0	150,146	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	894,467	0		54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	0	137,210	0		54.01
60.00	LABORATORY	0	605,010	0		60.00
65.00	RESPIRATORY THERAPY	0	139,925	0		65.00
65.01	SLEEP STUDIES	0	45,580	0		65.01
66.00	PHYSICAL THERAPY	0	131,387	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	127,593	0		71.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,436,369	1,896		73.00
73.01	ONCOLOGY	0	122,753	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	EMERGENCY	0	701,404	892		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	78,528	0		92.00
200.00	Subtotal (see instructions)	0	5,185,680	2,788		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	5,185,680	2,788		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315

Period: From 10/01/2010

Worksheet D

Component CCN: 142315

To 09/30/2011

Part V

Date/Time Prepared: 3/28/2012 4:10 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.493410	0	0	0	50.00
53.00 ANESTHESIOLOGY	2.753312	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.214962	0	0	0	54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	0.154106	0	0	0	54.01
60.00 LABORATORY	0.224227	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0.225507	0	0	0	65.00
65.01 SLEEP STUDIES	0.172087	0	0	0	65.01
66.00 PHYSICAL THERAPY	0.391891	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406361	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0.524681	0	0	0	73.00
73.01 ONCOLOGY	0.799567	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
91.00 EMERGENCY	0.379208	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.876707	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315

Period: From 10/01/2010

Worksheet D

Component CCN:142315

To 09/30/2011

Part V

Date/Time Prepared: 3/28/2012 4:10 pm

Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0		54.01
60.00 LABORATORY	0	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
65.01 SLEEP STUDIES	0	0	0		65.01
66.00 PHYSICAL THERAPY	0	0	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01 ONCOLOGY	0	0	0		73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00 Net Charges (Line 200 +/- line 201)	0	0	0		202.00

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,794 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,350 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,350 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			141 5.00
6.00	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)			285 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			5 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			13 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,849 9.00
10.00	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)			141 10.00
11.00	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)			285 11.00
12.00	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			0 12.00
13.00	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)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			93.63 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			94.12 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,195,942 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			468 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			1,224 25.00
26.00	Total swing-bed cost (see instructions)			491,877 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,704,065 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			2,430,335 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			2,430,335 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.112631 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,034.19 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,704,065 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,150.67 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,127,589 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			2,127,589 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D-1

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Title XVIII			Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,310,947	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,438,536	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 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)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					162,244	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					327,941	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					490,185	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					111	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,150.67	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					127,724	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D-1

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Cost	Title XVIII		Hospital	Cost	
		Routine Cost (from line 27)	column 1 + column 2		Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0 90.00
91.00	Nursing School cost	0	0	0.000000	0	0 91.00
92.00	Allied health cost	0	0	0.000000	0	0 92.00
93.00	All other Medical Education	0	0	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet D-3

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description	Title XVIII		Hospital	
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS		1,990,255		30.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.493410	151,507	74,755	50.00
53.00 ANESTHESIOLOGY	2.753312	31,314	86,217	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.214962	576,569	123,940	54.00
54.01 NUCLEAR MEDICINE - DIAGNOSTIC	0.154106	3,636	560	54.01
60.00 LABORATORY	0.224227	710,083	159,220	60.00
65.00 RESPIRATORY THERAPY	0.225507	475,178	107,156	65.00
65.01 SLEEP STUDIES	0.172087	0	0	65.01
66.00 PHYSICAL THERAPY	0.391891	84,812	33,237	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406361	538,069	218,650	71.00
73.00 DRUGS CHARGED TO PATIENTS	0.524681	966,706	507,212	73.00
73.01 ONCOLOGY	0.799567	0	0	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00 EMERGENCY	0.379208	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.876707	0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)		3,537,874	1,310,947	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00 Net Charges (line 200 minus line 201)		3,537,874		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141315

Period: From 10/01/2010

Worksheet D-3

Component CCN: 14z315

To 09/30/2011

Date/Time Prepared: 3/28/2012 4:10 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		235,380		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.493410	4,112	2,029	50.00
53.00	ANESTHESIOLOGY	2.753312	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.214962	16,619	3,572	54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	0.154106	0	0	54.01
60.00	LABORATORY	0.224227	42,581	9,548	60.00
65.00	RESPIRATORY THERAPY	0.225507	58,152	13,114	65.00
65.01	SLEEP STUDIES	0.172087	0	0	65.01
66.00	PHYSICAL THERAPY	0.391891	49,430	19,371	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.406361	59,682	24,252	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.524681	207,415	108,827	73.00
73.01	ONCOLOGY	0.799567	1,043	834	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	EMERGENCY	0.379208	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.876707	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		439,034	181,547	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		439,034		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/28/2012 4:10 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,188,468	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,188,468	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,240,353	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		31,743	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,542,564	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,666,046	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,666,046	30.00
31.00	Primary payer payments		985	31.00
32.00	Subtotal (line 30 minus line 31)		2,665,061	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		546,745	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		546,745	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		522,327	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		3,211,806	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		3,211,806	40.00
41.00	Interim payments		3,354,553	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-142,747	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		27,441	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet E
Part B
Date/Time Prepared:
3/28/2012 4:10 pm

Title XVIII	Hospital	Cost	Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0

112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
3/28/2012 4:10 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,875,598		3,400,402	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	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. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	04/15/2011	105,518	04/15/2011	100,954	3.01	
3.02		09/23/2011	49,762		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	09/23/2011	146,803	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		155,280		-45,849	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or Wkst. E-3, line and column as appropriate)		3,030,878		3,354,553	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		145,500		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		142,747	6.02	
7.00	Total Medicare program liability (see instructions)		3,176,378		3,211,806	7.00	
				Contractor Number	Date (Mo/day/yr)		
				1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141315

Period: From 10/01/2010

Worksheet E-1

Component CCN: 142315

To 09/30/2011

Part I

Date/Time Prepared: 3/28/2012 4:10 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		593,228		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	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. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	04/15/2011	3,010		0	3.01	
3.02		09/23/2011	1,042		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		4,052		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		597,280		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		66,099		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		663,379		0	7.00	
						Contractor Number	Date (Mo/Day/Yr)
						1.00	2.00
8.00	Name of Contractor	0					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet E-1 Part II Date/Time Prepared: 3/28/2012 4:10 pm
		Title XVIII	Hospital	Cost
				1.00
DATA COLLECTION NEEDED FOR THE HIT CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14			592 1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,849 2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2			28 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,239 4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200			41,733,127 5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20			1,153,599 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet S-2, Part I line 168			1,022,172 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,022,172 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment(s)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			1,022,172 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
		Component CCN: 142315	Date/Time Prepared: 3/28/2012 4:10 pm	
		Title XVIII	Swing Beds - SNF	Cost
			Part A 1.00	Part B 2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		495,087	0 1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			0 2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		183,362	0 3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00 4.00
5.00	Program days		426	0 5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0 6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	0 7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		678,449	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		678,449	0 10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0 11.00
12.00	Subtotal (line 10 minus line 11)		678,449	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		15,070	0 13.00
14.00	80% of Part B costs (line 12 x 80%)			0 14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		663,379	0 15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 16.00
17.00	Reimbursable bad debts (see instructions)		0	0 17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0 18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		663,379	0 19.00
20.00	Interim payments		597,280	0 20.00
21.00	Tentative settlement (for contractor use only)		0	0 21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		66,099	0 22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		3,556	0 23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part V Date/Time Prepared: 3/28/2012 4:10 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services			3,438,536 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			3,438,536 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			3,472,921 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	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)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3,472,921 19.00
20.00	Deductibles (exclude professional component)			377,184 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,095,737 22.00
23.00	Coinsurance			1,415 23.00
24.00	Subtotal (line 22 minus line 23)			3,094,322 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			82,056 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			82,056 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			81,088 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			3,176,378 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			3,176,378 30.00
31.00	Interim payments			3,030,878 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			145,500 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			18,196 34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet G

Date/Time Prepared:
3/28/2012 4:10 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	1,886,351	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	8,862,369	0	0	0	4.00
5.00 Other receivable	-2,660	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-4,904,120	0	0	0	6.00
7.00 Inventory	530,791	0	0	0	7.00
8.00 Prepaid expenses	178,242	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	6,550,973	0	0	0	11.00
FIXED ASSETS					
12.00 Land	134,251	0	0	0	12.00
13.00 Land improvements	258,001	0	0	0	13.00
14.00 Accumulated depreciation	-191,958	0	0	0	14.00
15.00 Buildings	7,330,171	0	0	0	15.00
16.00 Accumulated depreciation	-3,066,024	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	6,581,565	0	0	0	23.00
24.00 Accumulated depreciation	-4,440,098	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	6,605,908	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	3,461	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	3,817	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	7,278	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	13,164,159	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	340,095	0	0	0	37.00
38.00 Salaries, wages, and fees payable	701,026	0	0	0	38.00
39.00 Payroll taxes payable	24,472	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	857,526	0	0	0	43.00
44.00 Other current liabilities	1,021,186	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	2,944,305	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	4,660,613	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	138,943	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	4,799,556	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	7,743,861	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	5,420,298	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	5,420,298	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	13,164,159	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
3/28/2012 4:10 pm

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
1.00 Fund balances at beginning of period		4,123,816		0		1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		1,247,160				2.00
3.00 Total (sum of line 1 and line 2)		5,370,976		0		3.00
4.00 RELEASED FROM RESTRICTION	33,835			0		4.00
5.00 CONTRIBUTIONS	385,090			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00 Total additions (sum of line 4-9)		418,925		0		10.00
11.00 Subtotal (line 3 plus line 10)		5,789,901		0		11.00
12.00 RELEASED FROM RESTRICTION	369,603			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00 Total deductions (sum of lines 12-17)		369,603		0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		5,420,298		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
3/28/2012 4:10 pm

	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
1.00 Fund balances at beginning of period		0		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)					2.00
3.00 Total (sum of line 1 and line 2)		0		0	3.00
4.00 RELEASED FROM RESTRICTION	0		0		4.00
5.00 CONTRIBUTIONS	0		0		5.00
6.00	0		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		0		0	10.00
11.00 Subtotal (line 3 plus line 10)		0		0	11.00
12.00 RELEASED FROM RESTRICTION	0		0		12.00
13.00	0		0		13.00
14.00	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		0		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
3/28/2012 4:10 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,430,335		2,430,335	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	235,380		235,380	5.00
6.00	Swing bed - NF	9,946		9,946	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,675,661		2,675,661	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,675,661		2,675,661	17.00
18.00	Ancillary services	4,942,075	0	4,942,075	18.00
19.00	Outpatient services	0	37,007,032	37,007,032	19.00
20.00	RURAL HEALTH CLINIC	0	1,411,946	1,411,946	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	7,617,736	38,418,978	46,036,714	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		20,081,685		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		20,081,685		43.00

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-3

Date/Time Prepared:
3/28/2012 4:10 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	46,036,714	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,348,399	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,688,315	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	20,081,685	4.00
5.00	Net income from service to patients (line 3 minus line 4)	606,630	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	336,336	6.00
7.00	Income from investments	8,938	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	53,143	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	139,473	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	102,640	24.00
25.00	Total other income (sum of lines 6-24)	640,530	25.00
26.00	Total (line 5 plus line 25)	1,247,160	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,247,160	29.00

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

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2010
To 09/30/2011

worksheet M-1
Date/Time Prepared:
3/28/2012 4:10 pm

		Title XVIII		Rural Health Clinic (RHC) I	Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	2.00
3.00	Nurse Practitioner	84,704	0	84,704	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	154,842	0	154,842	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	239,546	0	239,546	0	10.00
11.00	Physician Services Under Agreement	0	474,003	474,003	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	168,660	168,660	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	642,663	642,663	0	14.00
15.00	Medical Supplies	0	282	282	-282	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	13,709	13,709	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	13,991	13,991	-282	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	239,546	656,654	896,200	-282	22.00
COSTS OTHER THAN RHC/FOHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	32,632	32,632	0	29.00
30.00	Administrative Costs	146,257	29,652	175,909	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	146,257	62,284	208,541	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	385,803	718,938	1,104,741	-282	32.00

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

Provider CCN: 141315

Period:
From 10/01/2010
To 09/30/2011

Worksheet M-1

Component CCN: 143482

Date/Time Prepared:
3/28/2012 4:10 pm

		Adjustments	Net Expenses For Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	84,704	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	154,842	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	239,546	10.00
11.00	Physician Services Under Agreement	-54,157	419,846	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	168,660	13.00
14.00	Subtotal (sum of lines 11-13)	-54,157	588,506	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	13,709	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	13,709	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-54,157	841,761	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	32,632	29.00
30.00	Administrative Costs	-10,183	165,726	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-10,183	198,358	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-64,340	1,040,119	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2010
To 09/30/2011

Worksheet M-2
Date/Time Prepared:
3/28/2012 4:10 pm

Title XVIII			Rural Health Clinic (RHC) I	Cost
Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
1.00	2,00	3.00	4,00	5.00

VISITS AND PRODUCTIVITY

Positions					
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
1.00	0.00	0	4,200	0	1.00
2.00	0.00	0	2,100	0	2.00
3.00	0.91	2,542	2,100	1,911	3.00
4.00	0.91	2,542		1,911	4.00
5.00	0.00	0			5.00
6.00	0.00	0			6.00
7.00	0.00	0			7.00
7.01	0.00	0			7.01
7.02	0.00	0			7.02
8.00	0.91	2,542			8.00
9.00		7,263			9.00
					1.00

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10.00	Total costs of health care services (from worksheet M-1, column 7, line 22)	841,761	10.00
11.00	Total nonreimbursable costs (from worksheet M-1, column 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	841,761	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from worksheet M-1, column 7, line 31)	198,358	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	428,587	15.00
16.00	Total overhead (sum of lines 14 and 15)	626,945	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtract line 17 from line 16	626,945	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	626,945	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,468,706	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141315 Component CCN:143482	Period: From 10/01/2010 To 09/30/2011	worksheet M-3 Date/Time Prepared: 3/28/2012 4:10 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from worksheet M-2, line 20)			1,468,706 1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)			4,522 2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,464,184 3.00
4.00	Total visits (from worksheet M-2, column 5, line 8)			2,542 4.00
5.00	Physicians visits under agreement (from worksheet M-2, column 5, line 9)			7,263 5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,805 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			149.33 7.00
		Calculation of Limit (L)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	149.33	149.33	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	481	1,820	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	71,828	271,781	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	71,828	271,781	16.00
16.01	Total program charges (see instructions)(from contractor's records)		294,891	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		194,078	16.04
16.05	Total program cost (see instructions)	57,462	194,078	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		29,184	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		53,141	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		251,540	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		2,671	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		254,211	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		254,211	26.00
27.00	Interim payments		255,442	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		-1,231	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		1,449	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141315	Period: From 10/01/2010 To 09/30/2011	Worksheet M-4
		Component CCN:143482		Date/Time Prepared: 3/28/2012 4:10 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
			Pneumococcal 1.00	Influenza 2.00
1.00	Health care staff cost (from worksheet M-1, column 7, line 10)		239,546	239,546 1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000076	0.001431 2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		18	343 3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		433	1,798 4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		451	2,141 5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)		841,761	841,761 6.00
7.00	Total overhead (from worksheet M-2, line 16)		626,945	626,945 7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000536	0.002543 8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		336	1,594 9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		787	3,735 10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		8	151 11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		98.38	24.74 12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		2	100 13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		197	2,474 14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to worksheet M-3, line 2)			4,522 15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to worksheet M-3, line 21)			2,671 16.00

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

Provider CCN: 141315

Period: From 10/01/2010

Worksheet M-5

Component CCN: 143482

To 09/30/2011

Date/Time Prepared: 3/28/2012 4:10 pm

Title XVIII

Rural Health Clinic (RHC) I

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		239,954	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	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. (1)			3.00
Program to Provider				
3.01		04/15/2011	15,488	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		15,488	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		255,442	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,231	6.02
7.00	Total Medicare program liability (see instructions)		254,211	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00