

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 10/01/2011 To 09/30/2012	worksheet 5 Parts I-III Date/Time Prepared: 2/25/2013 8:21 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: 2/25/2013 Time: 8:21 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 certification 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 (141315) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/25/2013 Time: 8:21 pm
 m6eKc10Q6EiNtbs91uStlKKJTB0tu0
 ZIAMG0nuTdulH5kyaz:y35zqTEki0.
 29ea0eQOv10L49j5
 PI: Date: 2/25/2013 Time: 8:21 pm
 DhY1c3LmCnr7DTxrZozCkPvUDEVmG0
 VFjdt0ALQkw.m85XPoUKRIUppurRAC
 snMWAQMGsS0JwbwC

(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	387,061	0	0
2.00	Subprovider - IPF	0	0	0	0
3.00	Subprovider - IRF	0	0	0	0
4.00	SUBPROVIDER I	0	0	0	0
5.00	Swing bed - SNF	0	87,060	0	0
6.00	Swing bed - NF	0	0	0	0
7.00	SKILLED NURSING FACILITY	0	0	0	0
8.00	NURSING FACILITY	0	0	0	0
9.00	HOME HEALTH AGENCY I	0	0	0	0
10.00	RURAL HEALTH CLINIC I	0	76,604	0	0
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0
12.00	CMHC I	0	0	0	0
200.00	Total	0	474,121	0	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, 2012**

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 \$47,000.

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OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141315	Period: From 10/01/2011 To 09/30/2012	Worksheet 5 Parts I-III Date/Time Prepared: 2/25/2013 8:10 pm
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10. NPR Date:
 11. Contractor's Vendor Code: 4
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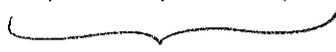
(Signed) _____
 Officer or Administrator of Provider(s)

Title _____

Date _____

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	401,180	341,483	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	89,927	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		78,542		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	491,107	420,025	0	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.


 911,132 Difference
 447,444

ADJUSTMENTS TO EXPENSES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8

Date/Time Prepared:
2/25/2013 8:10 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	-48,494	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	-1,550,889		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	45,309		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-71	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	-459	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-8	DIETARY	10.00 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		0		0.00 32.00
33.00	MISCELLANEOUS INCOME	B	-4,278	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01	MISCELLANEOUS RADIOLOGY INCOME	B	-2,384	RADIOLOGY-DIAGNOSTIC	54.00 33.01
33.02	MISCELLANEOUS SUPPLIES INCOME	B	-2,011	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 33.02
33.03	CABLE TELEVISION	A	-3,353	OPERATION OF PLANT	7.00 33.03
33.04	MISCELLANEOUS EXPENSE	A	-28,596	ADMINISTRATIVE & GENERAL	5.00 33.04
33.05	PUBLIC RELATIONS SALARIES	A	-22,600	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06	PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-6,989	EMPLOYEE BENEFITS	4.00 33.06
33.07	PUBLIC RELATIONS EXPENSES	A	-78,048	ADMINISTRATIVE & GENERAL	5.00 33.07
33.08	COFFEE SHOP RECEIPTS	B	-44,705	DIETARY	10.00 33.08
33.09	MEALS ON WHEELS	B	-3,066	DIETARY	10.00 33.09
33.10	LOBBYING EXPENSE	A	-8,013	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11	NON-RHC PHYSICIAN COST	A	-41,773	RURAL HEALTH CLINIC	88.00 33.11
33.12	CAH HIT ADJUSTMENT FOR DEPRECIATION	A	-343,223	CAP REL COSTS-MVBLE EQUIP	2.00 33.12
33.13	PROVIDER TAX	A	94,128	ADMINISTRATIVE & GENERAL	5.00 33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-2,049,523		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8

Date/Time Prepared:
2/25/2013 8:10 pm

Cost Center Description	Wkst. A-7 Ref.	\$,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		0	32.00
33.00 MISCELLANEOUS INCOME		0	33.00
33.01 MISCELLANEOUS RADIOLOGY INCOME		0	33.01
33.02 MISCELLANEOUS SUPPLIES INCOME		0	33.02
33.03 CABLE TELEVISION		0	33.03
33.04 MISCELLANEOUS EXPENSE		0	33.04
33.05 PUBLIC RELATIONS SALARIES		0	33.05
33.06 PUBLIC RELATIONS EMPLOYEE BENEFITS		0	33.06
33.07 PUBLIC RELATIONS EXPENSES		0	33.07
33.08 COFFEE SHOP RECEIPTS		0	33.08
33.09 MEALS ON WHEELS		0	33.09
33.10 LOBBYING EXPENSE		0	33.10
33.11 NON-RHC PHYSICIAN COST		0	33.11
33.12 CAH HIT ADJUSTMENT FOR DEPRECIATION		9	33.12
33.13 PROVIDER TAX		0	33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		0	50.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/25/2013 8:15 pm

	1.00	2.00	3.00	4.00								
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 640 WEST WASHINGTON		PO Box:								1.00	
2.00	City: PITTSFIELD		State: IL		Zip Code: 62363		County: PIKE				2.00	
	Component Name	CCN Number	CBA 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	1	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										8.00	
9.00	Hospital-Based SNF										9.00	
10.00	Hospital-Based NF										10.00	
11.00	Hospital-Based OLTC										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) I										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)					10/01/2011	09/30/2012				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	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0					23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 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 col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.					0	0	0	0	0	0	25.00
						Urban/Rural S	Date of Geogr					
						1.00	2.00					
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 in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2				27.00	
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 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/25/2013 8:15 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
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N				39.00
		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 additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
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 in column 1. 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		
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.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/25/2013 8:15 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, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			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	If line 63 is yes, then, for each primary care residency program in which you are training residents, 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 that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS					
70.00	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
Inpatient Rehabilitation Facility PPS					
75.00	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)(ii)(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		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
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.				86.00
		V	XIX		
		1.00	2.00		
Title V and XIX 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	N	N
		1.00	2.00	3.00	
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. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/25/2013 8:15 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.00	List amounts of malpractice premiums and paid losses:	136,718	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
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
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)		Y	14H132	140.00
		1.00	2.00	3.00	
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	
142.00	Street: BROADWAY AT 11TH STREET	PO Box:			
143.00	City: QUINCY	State: IL		Zip Code: 62301	
				1.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
				1.00	2.00
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.		N		146.00
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
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	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/25/2013 8:15 pm

							1.00	
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAS? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	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						0.00	166.00
							1.00	
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	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
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)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part II
Date/Time Prepared:
2/25/2013 8:15 pm

		Y/N	Date	
		1.00	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	Date	V/I
		1.00	2.00	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	Type	Date
		1.00	2.00	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	Legal Oper.	
		1.00	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.	N		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.	N		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.	N		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	Y/N	Date
		0	1.00	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	01/31/2013	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	N		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
				1.00
				2.00
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, x4159	CZIEGLER@BLESSINGHOSPITAL.COM	43.00

		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	01/31/2013	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
				3.00
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REVENUE INTEGRITY		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet 5-3
Part I
Date/Time Prepared:
2/25/2013 8:15 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	9,150	38,280.00	1.00
2.00 HMO					2.00
3.00 HMO IPF Subprovider					3.00
4.00 HMO IRF Subprovider					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	9,150	38,280.00	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	9,150	38,280.00	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

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	1,271	103	1,595	1.00	
2.00 HMO		62	0		2.00	
3.00 HMO IPF Subprovider		0	0		3.00	
4.00 HMO IRF Subprovider		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	300	0	300	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,571	103	1,895	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	1,571	103	1,895	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	2,506	0	8,982	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	98	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				18	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	364	1.00
2.00 HMO					17	2.00
3.00 HMO IPF subprovider						3.00
4.00 HMO IRF subprovider						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	160.87	0.00	0	364	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	9.01	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	169.88	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 10/01/2011
To 09/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2013 8:15 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)	38	513		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				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)	38	513		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 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/25/2013 8:15 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		2.00
		1.00		
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	Grant Award	Date	3.00
		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 or "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 to	
		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. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. 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
				XIX
				4.00
				Total Visits
				5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0 0 0 0 0 15.00

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

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-8
Date/Time Prepared:
2/25/2013 8:15 pm
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	
Facility hours of operations (1)						
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 10/01/2011
 To 09/30/2012

Worksheet S-8
 Date/Time Prepared:
 2/25/2013 8:15 pm

		Thursday		Friday		Cost
		from	to	from	to	
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 10/01/2011
To 09/30/2012

Worksheet S-8
Date/Time Prepared:
2/25/2013 8:15 pm

		Rural Health Clinic (RHC) I	Cost
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		Saturday		
		From	to	
11.00	Facility hours of operations (1) Clinic	07:00	12:00	11.00

				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.409126	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,504,622	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		6,837,086	6.00
7.00	Medicaid cost (line 1 times line 6)		2,797,230	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)		945,081	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)		945,081	19.00
				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	Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00		1,066,633	505,266	1,571,899
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	436,387	206,717	643,104
22.00	Partial payment by patients approved for charity care	7,707	3,579	11,286
23.00	Cost of charity care (line 21 minus line 22)	428,680	203,138	631,818
				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)		2,289,858	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		774,627	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,515,231	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		619,920	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,251,738	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,196,819	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A
Date/Time Prepared:
2/25/2013 8:15 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	00100	CAP REL COSTS-BLDG & FIXT		451,295	451,295	115,802	567,097	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		694,479	694,479	4,873	699,352	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	2,358,877	2,358,877	0	2,358,877	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,206,137	1,680,259	2,886,396	28,794	2,915,190	5.00
6.00	00600	MAINTENANCE & REPAIRS	304,529	182,541	487,070	0	487,070	6.00
7.00	00700	OPERATION OF PLANT	0	312,748	312,748	80,622	393,370	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	90,354	90,354	0	90,354	8.00
9.00	00900	HOUSEKEEPING	273,542	41,778	315,320	0	315,320	9.00
10.00	01000	DIETARY	192,380	110,177	302,557	0	302,557	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	214,884	50,894	265,778	-119,416	146,362	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	70,528	200,070	270,598	0	270,598	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	54,552	54,552	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	269,816	269,816	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,105,251	56,043	1,161,294	-55,439	1,105,855	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	464,598	187,553	652,151	-489	651,662	50.00
53.00	05300	ANESTHESIOLOGY	269,816	1,686	271,502	-271,502	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	643,428	597,900	1,241,328	-105	1,241,223	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	31,662	140,869	172,531	-35,271	137,260	54.01
60.00	06000	LABORATORY	483,235	621,693	1,104,928	-71,519	1,033,409	60.00
65.00	06500	RESPIRATORY THERAPY	169,797	58,647	228,444	-25,491	202,953	65.00
65.01	06501	SLEEP STUDIES	37,364	8,501	45,865	0	45,865	65.01
66.00	06600	PHYSICAL THERAPY	293,799	93,761	387,560	-23,659	363,901	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,865	151,215	194,080	136,259	330,339	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	329,417	2,079,078	2,408,495	-99	2,408,396	73.00
73.01	03480	ONCOLOGY	121,866	271,567	393,433	0	393,433	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	425,366	796,920	1,222,286	-401	1,221,885	88.00
91.00	09100	EMERGENCY	724,021	1,655,353	2,379,374	-314	2,379,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		113,707	113,707	-56,675	57,032	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,404,485	13,007,965	20,412,450	30,338	20,442,788	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	124,767	6,004	130,771	37	130,808	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	98,618	41,588	140,206	-30,375	109,831	193.05
200.00		TOTAL (SUM OF LINES 118-199)	7,627,870	13,055,557	20,683,427	0	20,683,427	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	567,097	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-343,223	356,129	2.00
3.00	00300 OTHER CAP REL COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS	-565,941	1,792,936	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	190,638	3,105,828	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	487,070	6.00
7.00	00700 OPERATION OF PLANT	-3,353	390,017	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-1,337	89,017	8.00
9.00	00900 HOUSEKEEPING	0	315,320	9.00
10.00	01000 DIETARY	-47,128	255,429	10.00
11.00	01100 CAFETERIA	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	146,362	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	16,713	287,311	16.00
17.00	01700 SOCIAL SERVICE	0	54,552	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	269,816	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1,105,855	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	651,662	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-21,068	1,220,155	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	137,260	54.01
60.00	06000 LABORATORY	0	1,033,409	60.00
65.00	06500 RESPIRATORY THERAPY	0	202,953	65.00
65.01	06501 SLEEP STUDIES	0	45,865	65.01
66.00	06600 PHYSICAL THERAPY	0	363,901	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,011	328,328	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	40,161	2,448,557	73.00
73.01	03480 ONCOLOGY	-261,000	132,433	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	-17,877	1,204,008	88.00
91.00	09100 EMERGENCY	-1,071,193	1,307,867	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	-57,032	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,143,651	18,299,137	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	130,808	192.00
193.00	19300 NONPAID WORKERS	0	0	193.00
193.01	19301 AUTOMATED HEALTH SERVICES	0	0	193.01
193.02	19302 RENAL	0	0	193.02
193.03	19303 LEASED SPACE	0	0	193.03
193.04	19304 UNUSED SPACE	0	0	193.04
193.05	19305 WELLNESS	0	109,831	193.05
200.00	TOTAL (SUM OF LINES 118-199)	-2,143,651	18,539,776	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	10,000	1.00
	TOTALS		0	10,000	
B - RECLASS UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	80,622	1.00
	TOTALS		0	80,622	
C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	136,259	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	37	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
	TOTALS		0	136,296	
D - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	56,583	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	92	2.00
	TOTALS		0	56,675	
E - RECLASS SOCIAL SERVICE SALARY					
1.00	SOCIAL SERVICE	17.00	54,552	0	1.00
	TOTALS		54,552	0	
F - RECLASS MISCELLAENOUS ANESTH EXPENSE					
1.00	OPERATING ROOM	50.00	0	1,686	1.00
	TOTALS		0	1,686	
H - RECLASS CRNA COSTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	269,816	0	1.00
	TOTALS		269,816	0	
I - RECLASS UR COORDINATOR SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	32,633	0	1.00
	TOTALS		32,633	0	
J - RECLASS NURSING MANAGER SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	86,783	0	1.00
	TOTALS		86,783	0	
K - RECLASS BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	54,000	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	54,000	
500.00	Grand Total: Increases		443,784	339,279	500.00

		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	10,000	0		1.00
	TOTALS		0	10,000			
B - RECLASS UTILITIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	80,622	0		1.00
	TOTALS		0	80,622			
C - RECLASS MEDICAL SUPPLIES EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	0	887	0		1.00
2.00	OPERATING ROOM	50.00	0	2,175	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	105	0		3.00
4.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	35,271	0		4.00
5.00	LABORATORY	60.00	0	71,519	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	25,491	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	34	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	99	0		8.00
9.00	EMERGENCY	91.00	0	314	0		9.00
10.00	RURAL HEALTH CLINIC	88.00	0	401	0		10.00
	TOTALS		0	136,296			
D - RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	56,675	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	56,675			
E - RECLASS SOCIAL SERVICE SALARY							
1.00	ADULTS & PEDIATRICS	30.00	54,552	0	0		1.00
	TOTALS		54,552	0			
F - RECLASS MISCELLANEOUS ANESTH EXPENSE							
1.00	ANESTHESIOLOGY	53.00	0	1,686	0		1.00
	TOTALS		0	1,686			
H - RECLASS CRNA COSTS							
1.00	ANESTHESIOLOGY	53.00	269,816	0	0		1.00
	TOTALS		269,816	0			
I - RECLASS UR COORDINATOR SALARY							
1.00	NURSING ADMINISTRATION	13.00	32,633	0	0		1.00
	TOTALS		32,633	0			
J - RECLASS NURSING MANAGER SALARY							
1.00	NURSING ADMINISTRATION	13.00	86,783	0	0		1.00
	TOTALS		86,783	0			
K - RECLASS BUILDING RENT							
1.00	PHYSICAL THERAPY	66.00	0	23,625	10		1.00
2.00	WELLNESS	193.05	0	30,375	10		2.00
	TOTALS		0	54,000			
500.00	Grand Total: Decreases		443,784	339,279			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/25/2013 8:15 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	4,500	0	4,500	0	1.00
2.00	Land Improvements	258,001	31,166	0	31,166	0	2.00
3.00	Buildings and Fixtures	6,448,376	45,500	0	45,500	0	3.00
4.00	Building Improvements	855,178	41,530	0	41,530	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,581,565	339,421	0	339,421	151,368	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,277,371	462,117	0	462,117	151,368	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,277,371	462,117	0	462,117	151,368	10.00
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	451,295	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	694,479	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,145,774	0	0	0	0	3.00
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	7,390,584	0	7,390,584	0.521926	5,219	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,769,618	0	6,769,618	0.478074	4,781	2.00
3.00	Total (sum of lines 1-2)	14,160,202	0	14,160,202	1.000000	10,000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/25/2013 8:15 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	138,751	0			1.00	
2.00	Land Improvements	289,167	0			2.00	
3.00	Buildings and Fixtures	6,493,876	0			3.00	
4.00	Building Improvements	896,708	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	6,769,618	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	14,588,120	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	14,588,120	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	451,295			1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	694,479			2.00	
3.00	Total (sum of lines 1-2)	0	1,145,774			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	5,219	451,295	54,000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	4,781	351,256	0	2.00
3.00	Total (sum of lines 1-2)	0	0	10,000	802,551	54,000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/25/2013 8:15 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	56,583	5,219	0	0	567,097	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	92	4,781	0	0	356,129	2.00	
3.00	Total (sum of lines 1-2)	56,675	10,000	0	0	923,226	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
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	-48,494	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	-1,550,889		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	45,309		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-71	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	-459	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-8	DIETARY	10.00 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		0		0.00 32.00
33.00 MISCELLANEOUS INCOME	B	-4,278	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01 MISCELLANEOUS RADIOLOGY INCOME	B	-2,384	RADIOLOGY-DIAGNOSTIC	54.00 33.01
33.02 MISCELLANEOUS SUPPLIES INCOME	B	-2,011	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 33.02
33.03 CABLE TELEVISION	A	-3,353	OPERATION OF PLANT	7.00 33.03
33.04 MISCELLANEOUS EXPENSE	A	-28,596	ADMINISTRATIVE & GENERAL	5.00 33.04
33.05 PUBLIC RELATIONS SALARIES	A	-22,600	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06 PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-6,989	EMPLOYEE BENEFITS	4.00 33.06
33.07 PUBLIC RELATIONS EXPENSES	A	-78,048	ADMINISTRATIVE & GENERAL	5.00 33.07
33.08 COFFEE SHOP RECEIPTS	B	-44,705	DIETARY	10.00 33.08
33.09 MEALS ON WHEELS	B	-3,066	DIETARY	10.00 33.09
33.10 LOBBYING EXPENSE	A	-8,013	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11 NON-RHC PHYSICIAN COST	A	-41,773	RURAL HEALTH CLINIC	88.00 33.11
33.12 CAH HIT ADJUSTMENT FOR DEPRECIATION	A	-343,223	CAP REL COSTS-MVBLE EQUIP	2.00 33.12
33.13		0		0.00 33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-2,143,651		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)			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	0		32.00
33.00 MISCELLANEOUS INCOME	0		33.00
33.01 MISCELLANEOUS RADIOLOGY INCOME	0		33.01
33.02 MISCELLANEOUS SUPPLIES INCOME	0		33.02
33.03 CABLE TELEVISION	0		33.03
33.04 MISCELLANEOUS EXPENSE	0		33.04
33.05 PUBLIC RELATIONS SALARIES	0		33.05
33.06 PUBLIC RELATIONS EMPLOYEE BENEFITS	0		33.06
33.07 PUBLIC RELATIONS EXPENSES	0		33.07
33.08 COFFEE SHOP RECEIPTS	0		33.08
33.09 MEALS ON WHEELS	0		33.09
33.10 LOBBYING EXPENSE	0		33.10
33.11 NON-RHC PHYSICIAN COST	0		33.11
33.12 CAH HIT ADJUSTMENT FOR DEPRECIATION	9		33.12
33.13	0		33.13
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 10/01/2011
To 09/30/2012

Worksheet A-8-1

Date/Time Prepared:
2/25/2013 8:15 pm

Line No.	Cost Center	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 PHYSICIANS	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
4.08	113.00 INTEREST EXPENSE	INTEREST	4.08
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.

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	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 10/01/2011
To 09/30/2012

Worksheet A-8-1

Date/Time Prepared:
2/25/2013 8:15 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	797,846	465,489	332,357	0	1.00
2.00	11,299	10,577	722	0	2.00
3.00	60,259	61,596	-1,337	0	3.00
4.00	860,348	1,419,300	-558,952	0	4.00
4.01	516,424	481,233	35,191	0	4.01
4.02	813,521	594,825	218,696	0	4.02
4.03	8,073	19,368	-11,295	0	4.03
4.04	32,000	32,184	-184	0	4.04
4.05	120,413	103,241	17,172	0	4.05
4.06	7,261	25,945	-18,684	0	4.06
4.07	76,161	36,000	40,161	0	4.07
4.08	0	8,538	-8,538	0	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	3,303,605	3,258,296	45,309	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 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/25/2013 8:15 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	33,246	0	1.00
2.00	73.01	ONCOLOGY	261,000	261,000	2.00
3.00	91.00	EMERGENCY	1,750,478	1,226,385	3.00
4.00	91.00	EMERGENCY	63,504	63,504	4.00
5.00	13.00	NURSING ADMINISTRATION	3,025	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			2,111,253	1,550,889	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/25/2013 8:15 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	33,246	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	524,093	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	3,025	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	560,364					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/25/2013 8:15 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 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/25/2013 8:15 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	0	1.00
2.00	0	261,000	2.00
3.00	0	1,226,385	3.00
4.00	0	63,504	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	1,550,889	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
2/25/2013 8:15 pm

		Physical Therapy					Cost	
							1.00	
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00	
2.00	Line 1 multiplied by 15 hours per week					780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					79	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)					104	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	128.16	116.29	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	103.23	76.13	57.10	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)	38.07	38.07	28.55			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)					9,757	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					6,640	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					16,397	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)					16,397	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)					67.08	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,322	22.00	
23.00	Total salary equivalency (see instructions)					52,322	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)					3,008	24.00	
25.00	Assistants (line 4 times column 3, line 11)					2,969	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					5,977	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)					631	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,608	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)					6,608	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
OUTSIDE SUPPLIERS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
2/25/2013 8:15 pm

		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		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		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)	76.13	57.10	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	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		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)					52,322	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					6,608	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)					58,930	63.00
64.00	Total cost of outside supplier services (from your records)					17,651	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					5,977	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					631	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					6,608	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					631	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					631	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 ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	567,097	567,097			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	356,129		356,129		2.00
4.00 00400	EMPLOYEE BENEFITS	1,792,936	0	0	1,792,936	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,105,828	98,042	69,201	307,171	5.00
6.00 00600	MAINTENANCE & REPAIRS	487,070	106,199	74,956	71,792	6.00
7.00 00700	OPERATION OF PLANT	390,017	0	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	89,017	0	0	0	8.00
9.00 00900	HOUSEKEEPING	315,320	8,256	5,827	64,487	9.00
10.00 01000	DIETARY	255,429	10,074	7,111	45,353	10.00
11.00 01100	CAFETERIA	0	3,641	2,570	0	11.00
13.00 01300	NURSING ADMINISTRATION	146,362	682	481	22,506	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	287,311	15,148	10,692	16,627	16.00
17.00 01700	SOCIAL SERVICE	54,552	650	459	12,861	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	269,816	0	0	63,609	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,105,855	46,189	32,601	247,701	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	651,662	30,928	21,829	109,529	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,220,155	21,158	14,934	151,688	54.00
54.01 03450	NUCLEAR MEDICINE - DIAGNOSTIC	137,260	2,350	1,659	7,464	54.01
60.00 06000	LABORATORY	1,033,409	11,215	7,916	113,922	60.00
65.00 06500	RESPIRATORY THERAPY	202,953	2,932	2,070	40,029	65.00
65.01 06501	SLEEP STUDIES	45,865	1,846	1,303	8,809	65.01
66.00 06600	PHYSICAL THERAPY	363,901	16,798	11,857	69,263	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	328,328	8,374	5,911	10,105	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,448,557	7,501	5,295	77,660	73.00
73.01 03480	ONCOLOGY	132,433	5,865	4,139	28,730	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,204,008	0	11,157	100,280	88.00
91.00 09100	EMERGENCY	1,307,867	27,841	19,651	170,687	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,299,137	425,689	311,619	1,740,273	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,996	2,115	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	130,808	29,982	21,162	29,414	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	AUTOMATED HEALTH SERVICES	0	0	0	0	193.01
193.02 19302	RENAL	0	10,470	0	0	193.02
193.03 19303	LEASED SPACE	0	27,031	0	0	193.03
193.04 19304	UNUSED SPACE	0	40,847	0	0	193.04
193.05 19305	WELLNESS	109,831	30,082	21,233	23,249	193.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	18,539,776	567,097	356,129	1,792,936	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/25/2013 8:15 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	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,580,242				5.00
6.00	00600	MAINTENANCE & REPAIRS	177,107	917,124			6.00
7.00	00700	OPERATION OF PLANT	93,342	0	483,359		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,304	0	0	110,321	8.00
9.00	00900	HOUSEKEEPING	94,269	22,413	11,313	0	9.00
10.00	01000	DIETARY	76,098	27,350	13,805	0	10.00
11.00	01100	CAFETERIA	1,486	9,886	4,990	0	11.00
13.00	01300	NURSING ADMINISTRATION	40,693	1,851	934	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,925	41,124	20,757	0	16.00
17.00	01700	SOCIAL SERVICE	16,399	1,765	891	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79,798	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	342,801	125,397	63,294	110,321	79,391
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	194,801	83,964	42,380	0	53,158
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	336,958	57,441	28,993	0	36,366
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	35,596	6,381	3,221	0	4,040
60.00	06000	LABORATORY	279,167	30,448	15,369	0	19,277
65.00	06500	RESPIRATORY THERAPY	59,350	7,961	4,018	0	5,040
65.01	06501	SLEEP STUDIES	13,839	5,011	2,529	0	3,172
66.00	06600	PHYSICAL THERAPY	110,526	45,604	23,019	0	28,872
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,415	22,734	11,475	0	14,393
73.00	07300	DRUGS CHARGED TO PATIENTS	607,663	20,365	10,279	0	12,893
73.01	03480	ONCOLOGY	40,965	15,921	8,036	0	10,080
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	314,823	42,914	0	0	0
91.00	09100	EMERGENCY	365,226	75,584	38,150	0	47,853
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,465,551	644,114	303,453	110,321	366,435
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,223	8,134	4,105	0	5,149
192.00	19200	PHYSICIANS' PRIVATE OFFICES	50,586	81,397	41,085	0	51,533
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0
193.02	19302	RENAL	2,506	28,424	14,347	0	17,995
193.03	19303	LEASED SPACE	6,469	73,387	23,174	0	29,068
193.04	19304	UNUSED SPACE	9,776	0	55,973	0	0
193.05	19305	WELLNESS	44,131	81,668	41,222	0	51,705
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,580,242	917,124	483,359	110,321	521,885

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/25/2013 8:15 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	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	452,536					10.00
11.00	01100	0	28,832				11.00
13.00	01300	0	498	215,179			13.00
16.00	01600	0	368	0	496,988		16.00
17.00	01700	0	284	0	0	88,978	17.00
19.00	01900	0	1,406	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	452,536	5,476	74,696	26,253	88,978	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,421	34,674	30,938	0	50.00
53.00	05300	0	0	0	2,077	0	53.00
54.00	05400	0	3,354	443	139,618	0	54.00
54.01	03450	0	165	3,184	18,881	0	54.01
60.00	06000	0	2,519	19	81,280	0	60.00
65.00	06500	0	885	9,557	21,608	0	65.00
65.01	06501	0	195	0	5,404	0	65.01
66.00	06600	0	1,531	0	19,626	0	66.00
71.00	07100	0	223	0	13,286	0	71.00
73.00	07300	0	1,717	0	69,632	0	73.00
73.01	03480	0	635	11,612	4,211	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	2,217	17,019	0	0	88.00
91.00	09100	0	3,774	56,433	64,174	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		452,536	27,668	207,637	496,988	88,978	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	650	7,542	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	0	514	0	0	0	193.05
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		452,536	28,832	215,179	496,988	88,978	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/25/2013 8:15 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	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
16.00	01600					16.00
17.00	01700					17.00
19.00	01900	414,629				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	2,801,489	0	2,801,489	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	1,256,284	0	1,256,284	50.00
53.00	05300	414,629	416,706	0	416,706	53.00
54.00	05400	0	2,011,108	0	2,011,108	54.00
54.01	03450	0	220,201	0	220,201	54.01
60.00	06000	0	1,594,541	0	1,594,541	60.00
65.00	06500	0	356,403	0	356,403	65.00
65.01	06501	0	87,973	0	87,973	65.01
66.00	06600	0	690,997	0	690,997	66.00
71.00	07100	0	499,244	0	499,244	71.00
73.00	07300	0	3,261,562	0	3,261,562	73.00
73.01	03480	0	262,627	0	262,627	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	1,692,418	0	1,692,418	88.00
91.00	09100	0	2,177,240	0	2,177,240	91.00
92.00	09200	0		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	0		0		113.00
118.00		414,629	17,328,793	0	17,328,793	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	23,722	0	23,722	190.00
192.00	19200	0	444,159	0	444,159	192.00
193.00	19300	0	0	0	0	193.00
193.01	19301	0	0	0	0	193.01
193.02	19302	0	73,742	0	73,742	193.02
193.03	19303	0	159,129	0	159,129	193.03
193.04	19304	0	106,596	0	106,596	193.04
193.05	19305	0	403,635	0	403,635	193.05
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		414,629	18,539,776	0	18,539,776	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/25/2013 8:15 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 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	98,042	69,201	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	106,199	74,956	6.00
7.00 00700	OPERATION OF PLANT	0	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	8,256	5,827	9.00
10.00 01000	DIETARY	0	10,074	7,111	10.00
11.00 01100	CAFETERIA	0	3,641	2,570	11.00
13.00 01300	NURSING ADMINISTRATION	0	682	481	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	15,148	10,692	16.00
17.00 01700	SOCIAL SERVICE	0	650	459	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	46,189	32,601	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	30,928	21,829	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	21,158	14,934	54.00
54.01 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	2,350	1,659	54.01
60.00 06000	LABORATORY	0	11,215	7,916	60.00
65.00 06500	RESPIRATORY THERAPY	0	2,932	2,070	65.00
65.01 06501	SLEEP STUDIES	0	1,846	1,303	65.01
66.00 06600	PHYSICAL THERAPY	0	16,798	11,857	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,374	5,911	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	7,501	5,295	73.00
73.01 03480	ONCOLOGY	0	5,865	4,139	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	0	11,157	88.00
91.00 09100	EMERGENCY	0	27,841	19,651	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	425,689	311,619	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,996	2,115	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	29,982	21,162	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
193.01 19301	AUTOMATED HEALTH SERVICES	0	0	0	193.01
193.02 19302	RENAL	0	10,470	0	193.02
193.03 19303	LEASED SPACE	0	27,031	0	193.03
193.04 19304	UNUSED SPACE	0	40,847	0	193.04
193.05 19305	WELLNESS	0	30,082	21,233	193.05
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers		0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	567,097	356,129	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/25/2013 8:15 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	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	167,243					5.00
6.00	00600	8,273	189,428				6.00
7.00	00700	4,360	0	4,360			7.00
8.00	00800	995	0	0	995		8.00
9.00	00900	4,404	4,629	102	0	23,218	9.00
10.00	01000	3,555	5,649	125	0	770	10.00
11.00	01100	69	2,042	45	0	278	11.00
13.00	01300	1,901	382	8	0	52	13.00
16.00	01600	3,687	8,494	187	0	1,158	16.00
17.00	01700	766	365	8	0	50	17.00
19.00	01900	3,728	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	16,014	25,901	570	995	3,532	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,100	17,342	382	0	2,365	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	15,741	11,864	262	0	1,618	54.00
54.01	03450	1,663	1,318	29	0	180	54.01
60.00	06000	13,041	6,289	139	0	858	60.00
65.00	06500	2,772	1,644	36	0	224	65.00
65.01	06501	646	1,035	23	0	141	65.01
66.00	06600	5,163	9,419	208	0	1,285	66.00
71.00	07100	3,943	4,696	104	0	640	71.00
73.00	07300	28,382	4,206	93	0	574	73.00
73.01	03480	1,914	3,289	72	0	448	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	14,707	8,864	0	0	0	88.00
91.00	09100	17,061	15,611	344	0	2,129	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		161,885	133,039	2,737	995	16,302	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	57	1,680	37	0	229	190.00
192.00	19200	2,363	16,812	371	0	2,293	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	117	5,871	129	0	801	193.02
193.03	19303	302	15,158	209	0	1,293	193.03
193.04	19304	457	0	505	0	0	193.04
193.05	19305	2,062	16,868	372	0	2,300	193.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		167,243	189,428	4,360	995	23,218	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

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	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	27,284					10.00
11.00	01100	0	8,645				11.00
13.00	01300	0	149	3,655			13.00
16.00	01600	0	110	0	39,476		16.00
17.00	01700	0	85	0	0	2,383	17.00
19.00	01900	0	422	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,284	1,643	1,269	2,086	2,383	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	726	589	2,458	0	50.00
53.00	05300	0	0	0	165	0	53.00
54.00	05400	0	1,006	8	11,078	0	54.00
54.01	03450	0	49	54	1,500	0	54.01
60.00	06000	0	755	0	6,459	0	60.00
65.00	06500	0	265	162	1,717	0	65.00
65.01	06501	0	58	0	429	0	65.01
66.00	06600	0	459	0	1,560	0	66.00
71.00	07100	0	67	0	1,056	0	71.00
73.00	07300	0	515	0	5,533	0	73.00
73.01	03480	0	190	197	335	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	665	289	0	0	88.00
91.00	09100	0	1,132	959	5,100	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		27,284	8,296	3,527	39,476	2,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	195	128	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	0	154	0	0	0	193.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		27,284	8,645	3,655	39,476	2,383	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/25/2013 8:15 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	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,150			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		160,467	0	160,467
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		85,719	0	85,719
53.00	05300	ANESTHESIOLOGY		165	0	165
54.00	05400	RADIOLOGY-DIAGNOSTIC		77,669	0	77,669
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		8,802	0	8,802
60.00	06000	LABORATORY		46,672	0	46,672
65.00	06500	RESPIRATORY THERAPY		11,822	0	11,822
65.01	06501	SLEEP STUDIES		5,481	0	5,481
66.00	06600	PHYSICAL THERAPY		46,749	0	46,749
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		24,791	0	24,791
73.00	07300	DRUGS CHARGED TO PATIENTS		52,099	0	52,099
73.01	03480	ONCOLOGY		16,449	0	16,449
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		35,682	0	35,682
91.00	09100	EMERGENCY		89,828	0	89,828
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	662,395	0	662,395
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,114	0	7,114
192.00	19200	PHYSICIANS' PRIVATE OFFICES		73,306	0	73,306
193.00	19300	NONPAID WORKERS		0	0	0
193.01	19301	AUTOMATED HEALTH SERVICES		0	0	0
193.02	19302	RENAL		17,388	0	17,388
193.03	19303	LEASED SPACE		43,993	0	43,993
193.04	19304	UNUSED SPACE		41,809	0	41,809
193.05	19305	WELLNESS		73,071	0	73,071
200.00		Cross Foot Adjustments	4,150	4,150	0	4,150
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,150	923,226	0	923,226

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	124,742				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		110,985			2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	7,605,270		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,566	21,566	1,302,953	-3,580,242	5.00
6.00	00600	MAINTENANCE & REPAIRS	23,360	23,360	304,529	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,816	1,816	273,542	0	9.00
10.00	01000	DIETARY	2,216	2,216	192,379	0	10.00
11.00	01100	CAFETERIA	801	801	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	150	150	95,468	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,332	3,332	70,528	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	54,552	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	269,816	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,160	10,160	1,050,699	0	30.00
ANCELLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,803	6,803	464,598	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,654	4,654	643,428	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	517	517	31,662	0	54.01
60.00	06000	LABORATORY	2,467	2,467	483,235	0	60.00
65.00	06500	RESPIRATORY THERAPY	645	645	169,797	0	65.00
65.01	06501	SLEEP STUDIES	406	406	37,364	0	65.01
66.00	06600	PHYSICAL THERAPY	3,695	3,695	293,799	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,842	1,842	42,865	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650	1,650	329,417	0	73.00
73.01	03480	ONCOLOGY	1,290	1,290	121,866	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,477	425,366	0	88.00
91.00	09100	EMERGENCY	6,124	6,124	724,021	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	93,637	97,114	7,381,884	-3,580,242	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	659	659	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,595	6,595	124,768	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	193.01
193.02	19302	RENAL	2,303	0	0	0	193.02
193.03	19303	LEASED SPACE	5,946	0	0	0	193.03
193.04	19304	UNUSED SPACE	8,985	0	0	0	193.04
193.05	19305	WELLNESS	6,617	6,617	98,618	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)	567,097	356,129	1,792,936		202.00
203.00		Unit cost multiplier (wkst. B, Part I)	4.546159	3.208803	0.235749		203.00
204.00		Cost to be allocated (per wkst. B, Part II)			0		204.00
205.00		Unit cost multiplier (wkst. B, Part II)			0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

worksheet B-1

Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQ. FEET)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQ. FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	74,308					6.00
7.00	00700		77,590				7.00
8.00	00800			1,895			8.00
9.00	00900	1,816	1,816		66,789		9.00
10.00	01000	2,216	2,216		2,216	1,895	10.00
11.00	01100	801	801		801		11.00
13.00	01300	150	150		150		13.00
16.00	01600	3,332	3,332		3,332		16.00
17.00	01700	143	143		143		17.00
19.00	01900						19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,160	10,160	1,895	10,160	1,895	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,803	6,803		6,803		50.00
53.00	05300						53.00
54.00	05400	4,654	4,654		4,654		54.00
54.01	03450	517	517		517		54.01
60.00	06000	2,467	2,467		2,467		60.00
65.00	06500	645	645		645		65.00
65.01	06501	406	406		406		65.01
66.00	06600	3,695	3,695		3,695		66.00
71.00	07100	1,842	1,842		1,842		71.00
73.00	07300	1,650	1,650		1,650		73.00
73.01	03480	1,290	1,290		1,290		73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	3,477					88.00
91.00	09100	6,124	6,124		6,124		91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		52,188	48,711	1,895	46,895	1,895	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	659	659		659		190.00
192.00	19200	6,595	6,595		6,595		192.00
193.00	19300						193.00
193.01	19301						193.01
193.02	19302	2,303	2,303		2,303		193.02
193.03	19303	5,946	3,720		3,720		193.03
193.04	19304		8,985				193.04
193.05	19305	6,617	6,617		6,617		193.05
200.00							200.00
201.00							201.00
202.00		917,124	483,359	110,321	521,885	452,536	202.00
203.00		12.342197	6.229656	58.216887	7.813936	238.805277	203.00
204.00		189,428	4,360	995	23,218	27,284	204.00
205.00		2.549228	0.056193	0.525066	0.347632	14.397889	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/25/2013 8:15 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	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	5,531,867					11.00
13.00	01300	95,468	2,204,934				13.00
16.00	01600	70,528	0	40,839,102			16.00
17.00	01700	54,552	0	0	1,895		17.00
19.00	01900	269,816	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,050,699	765,411	2,157,329	1,895		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	464,598	355,305	2,542,385	0	0	50.00
53.00	05300	0	0	170,656	0	100	53.00
54.00	05400	643,428	4,542	11,471,865	0	0	54.00
54.01	03450	31,662	32,622	1,551,600	0	0	54.01
60.00	06000	483,235	197	6,679,281	0	0	60.00
65.00	06500	169,797	97,930	1,775,687	0	0	65.00
65.01	06501	37,364	0	444,049	0	0	65.01
66.00	06600	293,799	0	1,612,770	0	0	66.00
71.00	07100	42,865	0	1,091,783	0	0	71.00
73.00	07300	329,417	0	5,722,066	0	0	73.00
73.01	03480	121,866	118,987	346,074	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	425,366	174,397	0	0	0	88.00
91.00	09100	724,021	578,262	5,273,557	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		5,308,481	2,127,653	40,839,102	1,895	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	124,768	77,281	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	98,618	0	0	0	0	193.05
200.00							200.00
201.00							201.00
202.00		28,832	215,179	496,988	88,978	414,629	202.00
203.00		0.005212	0.097590	0.012169	46.954090	4,146.290000	203.00
204.00		8,645	3,655	39,476	2,383	4,150	204.00
205.00		0.001563	0.001658	0.000967	1.257520	41.500000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part 1
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		Total Cost (From Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	Cost
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
Costs							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,801,489		2,801,489	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,256,284		1,256,284	0	0	50.00
53.00	05300 ANESTHESIOLOGY	416,706		416,706	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,011,108		2,011,108	0	0	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	220,201		220,201	0	0	54.01
60.00	06000 LABORATORY	1,594,541		1,594,541	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	356,403	0	356,403	0	0	65.00
65.01	06501 SLEEP STUDIES	87,973	0	87,973	0	0	65.01
66.00	06600 PHYSICAL THERAPY	690,997	0	690,997	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	499,244		499,244	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,261,562		3,261,562	0	0	73.00
73.01	03480 ONCOLOGY	262,627		262,627	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1,692,418		1,692,418	0	0	88.00
91.00	09100 EMERGENCY	2,177,240		2,177,240	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	137,756		137,756	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	17,466,549	0	17,466,549	0	0	200.00
201.00	Less Observation Beds	137,756		137,756			201.00
202.00	Total (see instructions)	17,328,793	0	17,328,793	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/25/2013 8:15 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,029,411		2,029,411			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	169,362	2,373,023	2,542,385	0.494136	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	38,687	131,969	170,656	2.441789	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	579,440	10,892,425	11,471,865	0.175308	0.000000	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	12,895	1,538,705	1,551,600	0.141919	0.000000	54.01
60.00	06000 LABORATORY	739,866	5,939,415	6,679,281	0.238729	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	664,887	1,110,800	1,775,687	0.200713	0.000000	65.00
65.01	06501 SLEEP STUDIES	0	444,049	444,049	0.198116	0.000000	65.01
66.00	06600 PHYSICAL THERAPY	124,966	1,487,804	1,612,770	0.428454	0.000000	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	471,626	620,157	1,091,783	0.457274	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	937,310	4,784,756	5,722,066	0.569997	0.000000	73.00
73.01	03480 ONCOLOGY	0	346,074	346,074	0.758875	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	1,516,534	1,516,534			88.00
91.00	09100 EMERGENCY	27,500	5,246,057	5,273,557	0.412860	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	127,918	127,918	1.076909	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	5,795,950	36,559,686	42,355,636			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	5,795,950	36,559,686	42,355,636			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000			54.01
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	06501 SLEEP STUDIES	0.000000			65.01
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	03480 ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 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 10/01/2011
To 09/30/2012

worksheet D
Part II
Date/Time Prepared:
2/25/2013 8:15 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)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	85,719	2,542,385	0.033716	99,159	3,343	50.00
53.00	05300	ANESTHESIOLOGY	165	170,656	0.000967	19,399	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,669	11,471,865	0.006770	412,892	2,795	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	8,802	1,551,600	0.005673	10,224	58	54.01
60.00	06000	LABORATORY	46,672	6,679,281	0.006988	586,077	4,096	60.00
65.00	06500	RESPIRATORY THERAPY	11,822	1,775,687	0.006658	476,700	3,174	65.00
65.01	06501	SLEEP STUDIES	5,481	444,049	0.012343	0	0	65.01
66.00	06600	PHYSICAL THERAPY	46,749	1,612,770	0.028987	63,854	1,851	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,791	1,091,783	0.022707	351,177	7,974	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,099	5,722,066	0.009105	651,544	5,932	73.00
73.01	03480	ONCOLOGY	16,449	346,074	0.047530	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	35,682	1,516,534	0.023529	0	0	88.00
91.00	09100	EMERGENCY	89,828	5,273,557	0.017034	2,397	41	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	127,918	0.000000	0	0	92.00
200.00		Total (lines 50-199)	501,928	40,326,225		2,673,423	29,283	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		Title XVIII				Hospital	Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	414,629	0	0	0	414,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	414,629	0	0	0	414,629	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		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	Cost	
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,542,385	0.000000	0.000000	99,159	50.00
53.00	05300	ANESTHESIOLOGY	0	170,656	2.429619	0.000000	19,399	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,471,865	0.000000	0.000000	412,892	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	1,551,600	0.000000	0.000000	10,224	54.01
60.00	06000	LABORATORY	0	6,679,281	0.000000	0.000000	586,077	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,775,687	0.000000	0.000000	476,700	65.00
65.01	06501	SLEEP STUDIES	0	444,049	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,612,770	0.000000	0.000000	63,854	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,091,783	0.000000	0.000000	351,177	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,722,066	0.000000	0.000000	651,544	73.00
73.01	03480	ONCOLOGY	0	346,074	0.000000	0.000000	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,516,534	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	5,273,557	0.000000	0.000000	2,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	127,918	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	40,326,225			2,673,423	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 8:15 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	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	47,132	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	47,132	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0			54.01
60.00	06000 LABORATORY	0	0			60.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
65.01	06501 SLEEP STUDIES	0	0			65.01
66.00	06600 PHYSICAL THERAPY	0	0			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
73.01	03480 ONCOLOGY	0	0			73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 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 10/01/2011
To 09/30/2012

Worksheet D
Part V
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		Cost to Charge Ratio From worksheet C, Part I, col. 9	Charges		Hospital	Cost	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)			Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.494136	0	1,189,099	0	50.00
53.00	05300	ANESTHESIOLOGY	2.441789	0	53,735	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175308	0	4,531,704	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.141919	0	945,560	0	54.01
60.00	06000	LABORATORY	0.238729	0	2,462,944	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.200713	0	628,008	0	65.00
65.01	06501	SLEEP STUDIES	0.198116	0	184,304	0	65.01
66.00	06600	PHYSICAL THERAPY	0.428454	0	541,657	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.457274	0	290,060	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.569997	0	3,132,813	2,436	73.00
73.01	03480	ONCOLOGY	0.758875	0	199,324	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
91.00	09100	EMERGENCY	0.412860	0	1,860,909	1,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.076909	0	86,238	0	92.00
200.00		Subtotal (see instructions)		0	16,106,355	3,965	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	16,106,355	3,965	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

worksheet D
Part V
Date/Time Prepared:
2/25/2013 8:15 pm

		Title XVIII		Hospital	Cost
Cost Center Description		Costs			
		PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
		5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	587,577	0	50.00
53.00	05300 ANESTHESIOLOGY	0	131,210	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	794,444	0	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	134,193	0	54.01
60.00	06000 LABORATORY	0	587,976	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	126,049	0	65.00
65.01	06501 SLEEP STUDIES	0	36,514	0	65.01
66.00	06600 PHYSICAL THERAPY	0	232,075	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	132,637	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,785,694	1,389	73.00
73.01	03480 ONCOLOGY	0	151,262	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100 EMERGENCY	0	768,295	631	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	92,870	0	92.00
200.00	Subtotal (see instructions)	0	5,560,796	2,020	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net charges (line 200 +/- line 201)	0	5,560,796	2,020	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315

Period: From 10/01/2011

Worksheet D

Component CCN: 142315

To 09/30/2012

Part V

Date/Time Prepared: 2/25/2013 8:15 pm

		Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost	
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.494136	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2.441789	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175308	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.141919	0	0	0	54.01
60.00	06000	LABORATORY	0.238729	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.200713	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0.198116	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.428454	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.457274	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.569997	0	0	0	73.00
73.01	03480	ONCOLOGY	0.758875	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
91.00	09100	EMERGENCY	0.412860	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.076909	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 10/01/2011

Worksheet D

Component CCN: 142315

To 09/30/2012

Part V

Date/Time Prepared: 2/25/2013 8:15 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost
	PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	54.01
60.00 06000 LABORATORY	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
65.01 06501 SLEEP STUDIES	0	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01 03480 ONCOLOGY	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Date/Time Prepared:
2/25/2013 8:15 pm

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,993 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,693 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,595 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		75 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)		225 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0 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)		0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,271 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)		75 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)		225 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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	94.12	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	94.62	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,801,489	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)	0	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)	0	25.00
26.00	Total swing-bed cost (see instructions)	421,698	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,379,791	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,873,732	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,873,732	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.270081	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)	1,174.75	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)	2,379,791	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)	1,405.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,786,594	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)	1,786,594	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
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)					966,105	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,752,699	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)					105,423	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					316,274	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					421,699	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)					98	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,405.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					137,756	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description	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)	Cost
	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 10/01/2011
To 09/30/2012

Worksheet D-3

Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,496,733		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.494136	99,159	48,998	50.00
53.00	05300 ANESTHESIOLOGY	2.441789	19,399	47,368	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175308	412,892	72,383	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.141919	10,224	1,451	54.01
60.00	06000 LABORATORY	0.238729	586,077	139,914	60.00
65.00	06500 RESPIRATORY THERAPY	0.200713	476,700	95,680	65.00
65.01	06501 SLEEP STUDIES	0.198116	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.428454	63,854	27,359	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.457274	351,177	160,584	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.569997	651,544	371,378	73.00
73.01	03480 ONCOLOGY	0.758875	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.412860	2,397	990	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.076909	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,673,423	966,105	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)		2,673,423		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 141315 Component CCN: 14Z315	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/25/2013 8:15 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.494136	0	0	50.00
53.00	05300 ANESTHESIOLOGY	2.441789	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175308	30,842	5,407	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.141919	0	0	54.01
60.00	06000 LABORATORY	0.238729	32,069	7,656	60.00
65.00	06500 RESPIRATORY THERAPY	0.200713	87,688	17,600	65.00
65.01	06501 SLEEP STUDIES	0.198116	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.428454	57,782	24,757	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.457274	51,715	23,648	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.569997	102,569	58,464	73.00
73.01	03480 ONCOLOGY	0.758875	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100 EMERGENCY	0.412860	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.076909	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		362,665	137,532	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)		362,665		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141315	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/25/2013 8:15 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,562,816	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)		5,562,816	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)		5,618,444	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)		35,006	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,710,475	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)		2,872,963	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)		2,872,963	30.00
31.00	Primary payer payments		59	31.00
32.00	Subtotal (line 30 minus line 31)		2,872,904	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)		706,309	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		706,309	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		706,309	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		3,579,213	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)		3,579,213	40.00
41.00	Interim payments		3,266,250	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)		312,963	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		28,520	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 10/01/2011
To 09/30/2012

Worksheet E
Part B
Date/Time Prepared:
2/25/2013 8:15 pm

	Title XVIII	Hospital	Cost
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
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 10/01/2011
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/25/2013 8:15 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		2,070,318		3,373,713	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	06/01/2012	64,264		0	3.01
3.02		09/17/2012	6,661		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	06/01/2012	89,083	3.50
3.51			0	09/17/2012	18,380	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)		70,925		-107,463	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)		2,141,243		3,266,250	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		387,061		312,963	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,528,304		3,579,213	7.00
				Contractor Number	Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141315
Component CCN: 142315

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/25/2013 8:15 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		438,162		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	06/01/2012	27,228		0	3.01
3.02		09/17/2012	8,077		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)		35,305		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)		473,467		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		87,060		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		560,527		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 10/01/2011
To 09/30/2012

Worksheet E-1
Part II
Date/Time Prepared:
2/25/2013 8:15 pm

		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14			513	1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,271	2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2			62	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,595	4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200			42,355,636	5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20			1,571,899	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			0	32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141315
Component CCN: 14Z315

Period:
From 10/01/2011
To 09/30/2012

worksheet E-2
Date/Time Prepared:
2/25/2013 8:15 pm

Title XVIII		Swing Beds - SNF		Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	425,916	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			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)	138,907	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	300	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		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	564,823	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	564,823	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)	564,823	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,296	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)	560,527	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)	560,527	0	19.00
20.00	Interim payments	473,467	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)	87,060	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	2,867	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-3
Part V
Date/Time Prepared:
2/25/2013 8:15 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		2,752,699	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)		2,752,699	4.00
5.00	Primary payer payments		4,212	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,776,014	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)		2,776,014	19.00
20.00	Deductibles (exclude professional component)		316,028	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,459,986	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,459,986	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		68,318	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		68,318	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		68,318	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,528,304	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)		2,528,304	30.00
31.00	Interim payments		2,141,243	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)		387,061	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		14,119	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 10/01/2011
To 09/30/2012

Worksheet G

Date/Time Prepared:
2/25/2013 8:15 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	3,393,981	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	10,909,575	0	0	0	4.00
5.00 Other receivable	-97,190	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-6,687,087	0	0	0	6.00
7.00 Inventory	495,462	0	0	0	7.00
8.00 Prepaid expenses	169,385	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)	8,184,126	0	0	0	11.00
FIXED ASSETS					
12.00 Land	138,751	0	0	0	12.00
13.00 Land improvements	289,167	0	0	0	13.00
14.00 Accumulated depreciation	-222,266	0	0	0	14.00
15.00 Buildings	7,452,271	0	0	0	15.00
16.00 Accumulated depreciation	-3,487,011	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	6,769,619	0	0	0	23.00
24.00 Accumulated depreciation	-4,983,210	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)	5,957,321	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	4,552	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	8,013	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	14,149,460	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	425,156	0	0	0	37.00
38.00 Salaries, wages, and fees payable	808,517	0	0	0	38.00
39.00 Payroll taxes payable	26,584	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	61,284	0	0	0	43.00
44.00 Other current liabilities	1,240,164	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	2,561,705	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	4,285,733	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)	4,424,676	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	6,986,381	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	7,163,079	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)	7,163,079	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	14,149,460	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-1

Date/Time Prepared:
2/25/2013 8:15 pm

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
1.00 Fund balances at beginning of period		5,420,298		0		1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		1,512,811				2.00
3.00 Total (sum of line 1 and line 2)		6,933,109		0		3.00
4.00 RELEASED FROM RESTRICTIONS	94,401		0			4.00
5.00 CONTRIBUTIONS	285,824		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)		380,225		0		10.00
11.00 Subtotal (line 3 plus line 10)		7,313,334		0		11.00
12.00 RELEASED FROM RESTRICTIONS	150,240		0			12.00
13.00 ROUNDING	15		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)		150,255		0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		7,163,079		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-1

Date/Time Prepared:
2/25/2013 8:15 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 RESTRICTIONS	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 RESTRICTIONS	0		0		12.00
13.00 ROUNDING	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 10/01/2011
To 09/30/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/25/2013 8:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,873,732		1,873,732	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	177,382		177,382	5.00
6.00	Swing bed - NF	0		0	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)	2,051,114		2,051,114	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)	2,051,114		2,051,114	17.00
18.00	Ancillary services	3,846,282	39,243,344	43,089,626	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,516,534	1,516,534	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)	5,897,396	40,759,878	46,657,274	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		20,683,427		29.00
30.00	PROVISION FOR BAD DEBTS	1,439,833			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)		1,439,833		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)		22,123,260		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141315

Period:
From 10/01/2011
To 09/30/2012

worksheet G-3

Date/Time Prepared:
2/25/2013 8:15 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	46,657,274	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,596,882	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,060,392	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	22,123,260	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-62,868	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	51,386	6.00
7.00	Income from investments	7,523	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	47,842	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	134,836	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	1,334,092	24.00
25.00	Total other income (sum of lines 6-24)	1,575,679	25.00
26.00	Total (line 5 plus line 25)	1,512,811	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)	1,512,811	29.00

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

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2011
To 09/30/2012

worksheet M-1
Date/Time Prepared:
2/25/2013 8:15 pm

		Rural Health Clinic (RHC) I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification	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	90,758	0	90,758	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	171,697	0	171,697	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)	262,455	0	262,455	0	10.00
11.00	Physician Services Under Agreement	0	481,233	481,233	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	222,770	222,770	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	704,003	704,003	0	14.00
15.00	Medical Supplies	0	401	401	-401	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	20,054	20,054	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	20,455	20,455	-401	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	262,455	724,458	986,913	-401	22.00
COSTS OTHER THAN RHC/FQHC 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	37,097	37,097	0	29.00
30.00	Administrative Costs	162,911	35,365	198,276	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	162,911	72,462	235,373	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	425,366	796,920	1,222,286	-401	32.00

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

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2011
To 09/30/2012

worksheet M-1
Date/Time Prepared:
2/25/2013 8:15 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	Rural Health Clinic (RHC) I	Cost
		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	90,758		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	171,697		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	262,455		10.00
11.00	Physician Services Under Agreement	-6,582	474,651		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	222,770		13.00
14.00	Subtotal (sum of lines 11-13)	-6,582	697,421		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	20,054		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	20,054		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-6,582	979,930		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	-11,295	25,802		29.00
30.00	Administrative Costs	0	198,276		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-11,295	224,078		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,877	1,204,008		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-2
Date/Time Prepared:
2/25/2013 8:15 pm

		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

1.00	Physician	1.60	6,458	4,200	6,720	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.89	2,391	2,100	1,869	3.00
4.00	Subtotal (sum of lines 1-3)	2.49	8,849		8,589	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	133		133	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.49	8,982		8,982	8.00
9.00	Physician Services Under Agreements		0		0	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)	979,930	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)	979,930	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)	224,078	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	488,410	15.00
16.00	Total overhead (sum of lines 14 and 15)	712,488	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtract line 17 from line 16	712,488	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	712,488	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,692,418	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141315 Component CCN: 143482	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3 Date/Time Prepared: 2/25/2013 8:15 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)			1,692,418 1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)			5,110 2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,687,308 3.00
4.00	Total visits (from worksheet M-2, column 5, line 8)			8,982 4.00
5.00	Physicians visits under agreement (from worksheet M-2, column 5, line 9)			0 5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,982 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			187.85 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)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	187.85	187.85	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	616	1,890	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	115,716	355,037	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	15.00
16.00	Total program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		470,753	16.00
16.01	Total program charges (see instructions)(from contractor's records)		363,126	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.)		356,637	16.04
16.05	Total program cost (see instructions)		356,637	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		24,957	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		67,634	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		356,637	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		2,807	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		359,444	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)		359,444	26.00
27.00	Interim payments		282,840	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)		76,604	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		1,938	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141315 Component CCN: 143482	Period: From 10/01/2011 To 09/30/2012	Worksheet M-4 Date/Time Prepared: 2/25/2013 8:15 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)	262,455	262,455	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000124	0.001379	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	33	362	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	867	1,697	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	900	2,059	5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)	979,930	979,930	6.00
7.00	Total overhead (from worksheet M-2, line 16)	712,488	712,488	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000918	0.002101	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	654	1,497	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,554	3,556	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	155	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	111.00	22.94	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	4	103	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	444	2,363	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)		5,110	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)		2,807	16.00

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

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-5
Date/Time Prepared:
2/25/2013 8:15 pm

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2,00	
1.00	Total interim payments paid to provider		290,579	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			0	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		06/01/2012	7,739	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)		-7,739	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		282,840	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		76,604	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		359,444	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00