

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: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/26/2013 6:35 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 3/28/2012	Time: 2:13 pm
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 GIBSON AREA HOSPITAL AND HEALTH SVCS (141317) 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.

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

Title

Date

	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	645,948	-205,771	-4,772	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	53,229	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	-9	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RHC - PAXTON CLINIC I	0	0	-25,000	0	0	10.00
10.01 RHC II -ONARGA CLINIC II	0	0	-14,785	0	0	10.01
10.02 RHC III - FORREST CLINIC III	0	0	93,699	0	0	10.02
10.03 RHC IV - HOOPESTON IV	0	0	66,761	0	0	10.03
10.04 RHC V - FARMER CITY V	0	0	12,286	0	0	10.04
10.05 RHC VI - GIBSON CITY VI	0	0	17,591	0	0	10.05
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	699,177	-55,228	-4,772	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 141317		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/26/2013 6:35 pm		
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 60936-		4.00 County: FORD			
1.00	Street: 1120 N. MELVIN	2.00	State: IL						
2.00	City: GIBSON CITY								

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	GIBSON AREA HOSPITAL AND HEALTH SVCS	141317	99914	1	01/03/2002	N	O	O	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	GIBSON COMMUNITY SWING BEDS	14Z317	99914		12/31/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GIBSON HOSPITAL ANNEX SNF	145979	99914		05/19/1999	N	P	O	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	MED CLINIC OF EAST CENTRAL ILLINOIS	143408	99914		01/01/1996	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	THE ONARGA CLINIC	143440	99914		10/01/1998	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	PRAIRIE FAMILY MEDICINE & OBSTETRI	148505	99914		06/30/2009	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	HOOPESTON CLINIC	148515	99914		08/11/2011	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	FARMER CITY CLINIC	148517	99914		09/16/2011	N	N	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	GIBSON CITY CLINIC	148516	99914		09/22/2011	N	N	N	15.05
16.00	Hospital-Based Health Clinic - FOHC									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.					2		N		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	Medicaid HMO days	Other Medicaid days			
							1.00	2.00	3.00
24.00	0	0	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	0	0	25.00

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		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	
		Beginning:	Ending:			
		1.00	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.	0			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.	0			38.00	
		Y/N	Y/N			
		1.00	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.				39.00	
		V	XVIII	XIX		
		1.00	2.00	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.	N			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	IME Average	Direct GME Average		
		1.00	2.00	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		
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	

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)							64.00
	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			
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)							65.00
			0.00	0.00	0.000000			
			1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)							66.00
			0.00	0.00	0.000000			
			1.00	2.00	3.00			
	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			

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	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)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
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		Y	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		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

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		V 1.00		XIX 2.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers	0.00		0.00		97.00	
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)	Y				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				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.	N				108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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.	N	N	N	N		109.00
		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
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
		Premiums 1.00	Losses 2.00	Insurance 3.00			
118.01	List amounts of malpractice premiums and paid losses:	662,476	0			0	
		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.			Y			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)			N			140.00

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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:	Contractor's Name:		Contractor's Number:		141.00								
142.00	Street:	PO Box:				142.00								
143.00	City:	State:		Zip Code:		143.00								
						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 155.00						
156.00	Subprovider - IPF	N		N		N		N 156.00						
157.00	Subprovider - IRF	N		N		N		N 157.00						
158.00	SUBPROVIDER							158.00						
159.00	SNF	N		N		N		N 159.00						
160.00	HOME HEALTH AGENCY	N		N		N		N 160.00						
161.00	CMHC			N		N		N 161.00						
						1.00								
Multi campus														
165.00	Is this hospital part of a Multi campus 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.						Y		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)						130,198		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: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/26/2013 6:35 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)	N			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	Type	Date	
		1.00	2.00	3.00	
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	Legal Oper.		
		1.00	2.00		
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		Y/N	
		Description	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	01/09/2013		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/26/2013 6:35 pm
		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 relieved for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y		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.	N		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.	Y		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		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.	N		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.	DAN	LI NHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LI NHART@MCGLADREY.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	01/09/2013	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.	MANAGER		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: 141317

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	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	23	8,418	57,048.00	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)		23	8,418	57,048.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	2	732	1,200.00	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	43.00				13.00
14.00 Total (see instructions)		25	9,150	58,248.00	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	44.00	5	1,830		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE	46.00	37	13,542		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 RHC - PAXTON CLINIC	88.00				26.00
26.01 RHC II -ONARGA CLINIC	88.01				26.01
26.02 RHC III - FORREST CLINIC	88.02				26.02
26.03 RHC IV - HOOPESTON	88.03				26.03
26.04 RHC V - FARMER CITY	88.04				26.04
26.05 RHC VI - GIBSON CITY	88.05				26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		67			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: 141317

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	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	1,237	357	2,377		1.00
2.00 HMO		18	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	895	0	1,014		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	40		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,132	357	3,431		7.00
8.00 INTENSIVE CARE UNIT	0	41	3	50		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	0		0	246		13.00
14.00 Total (see instructions)	0	2,173	360	3,727		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	0	848	0	1,288		19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE				11,841		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 RHC - PAXTON CLINIC	0	4,997	0	19,322		26.00
26.01 RHC II -ONARGA CLINIC	0	256	0	4,179		26.01
26.02 RHC III - FORREST CLINIC	0	1,078	0	5,673		26.02
26.03 RHC IV - HOOPESTON	0	629	0	2,106		26.03
26.04 RHC V - FARMER CITY	0	220	0	2,411		26.04
26.05 RHC VI - GIBSON CITY	0	129	0	4,211		26.05
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	295		28.00
29.00 Ambulance Trips		1,010				29.00
30.00 Employee discount days (see instruction)				0		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141317

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

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	375	1.00
2.00 HMO					5	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	385.49	0.00	0	375	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	0.00	3.45	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00	31.72	0.00			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 RHC - PAXTON CLINIC	0.00	30.91	0.00			26.00
26.01 RHC II -ONARGA CLINIC	0.00	6.24	0.00			26.01
26.02 RHC III - FORREST CLINIC	0.00	14.39	0.00			26.02
26.03 RHC IV - HOOPESTON	0.00	6.51	0.00			26.03
26.04 RHC V - FARMER CITY	0.00	4.84	0.00			26.04
26.05 RHC VI - GIBSON CITY	0.00	6.03	0.00			26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	489.58	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: 141317

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2013 6:35 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)	134	769		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)	134	769		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		61		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 RHC - PAXTON CLINIC				26.00
26.01 RHC II -ONARGA CLINIC				26.01
26.02 RHC III - FORREST CLINIC				26.02
26.03 RHC IV - HOOPESTON				26.03
26.04 RHC V - FARMER CITY				26.04
26.05 RHC VI - GIBSON CITY				26.05
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 WAGE RELATED COSTS	Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2013 6:35 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	0	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141317

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

Worksheet S-7

Date/Time Prepared:
2/26/2013 6:35 pm

		1.00	2.00	3.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	12/31/2002	2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	83	0	83	7.00
8.00	RHL	71	0	71	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	14	0	14	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	86	0	86	18.00
19.00	RHB	25	0	25	19.00
20.00	RHA	301	0	301	20.00
21.00	RMC	37	0	37	21.00
22.00	RMB	9	0	9	22.00
23.00	RMA	132	0	132	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	5	0	5	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	14	0	14	35.00
36.00	HB1	0	0	0	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	5	0	5	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	19	0	19	52.00
53.00	CA2	5	0	5	53.00
54.00	CA1	27	0	27	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141317

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

Worksheet S-7

Date/Time Prepared:
2/26/2013 6:35 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	3	0	3	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	7	0	7	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	4	0	4	199.00
200.00	TOTAL		848	0	848	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	16580	16580	201.00
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		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	144,418	54.43	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	265,333			207.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141317

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

Worksheet S-7

Date/Time Prepared:
2/26/2013 6:35 pm

		1.00	2.00	3.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	12/31/2002	2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	83	0	83	7.00
8.00	RHL	71	0	71	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	14	0	14	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	86	0	86	18.00
19.00	RHB	25	0	25	19.00
20.00	RHA	301	0	301	20.00
21.00	RMC	37	0	37	21.00
22.00	RMB	9	0	9	22.00
23.00	RMA	132	0	132	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	5	0	5	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	14	0	14	35.00
36.00	HB1	0	0	0	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	5	0	5	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	19	0	19	52.00
53.00	CA2	5	0	5	53.00
54.00	CA1	27	0	27	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141317

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

Worksheet S-7

Date/Time Prepared:
2/26/2013 6:35 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	3	0	3	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	7	0	7	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	4	0	4	199.00
200.00	TOTAL		848	0	848	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	16580	16580	201.00
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		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	144,418	54.43	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	265,333			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 143408		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
				Rural Health Clinic (RHC) I		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		225 MARKET STREET				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		PAXTON		IL		60957	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0	
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
10.00 Does this facility operate as other than an RHC or FOHC? 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	
		Sunday		Monday			
		from to		from to			
		1.00 2.00		3.00 4.00			
11.00 Facility hours of operations (1)				07:00 17:00			
11.00 Clinic							
1.00							
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	
		Provider name		CCN number			
		1.00		2.00			
14.00 Provider name, CCN number		PAXTON CLINIC		143408		14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 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	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	FORD		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	07:00	17:00	07:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm		
			Rural Health Clinic (RHC) I	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) I	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) II	Cost
		County 4.00		
2.00	City, State, Zip Code, County	ILLINOIS		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	07:00	19:00	07:00
				19:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm		
			Rural Health Clinic (RHC) II	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	07:00	19:00	08:00	16:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) II	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148505		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
				Rural Health Clinic (RHC) III		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		122 EAST WABASH AVENUE				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		FORREST		IL		61741-0058	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0	
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
10.00 Does this facility operate as other than an RHC or FOHC? 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	
		Sunday		Monday			
		from to		from to			
		1.00 2.00		3.00 4.00			
Facility hours of operations (1)							
11.00 Clinic		07:30		17:00			
1.00							
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	
		Provider name		CCN number			
		1.00		2.00			
14.00 Provider name, CCN number		FORREST CLINIC		148505		14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 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	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148505		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
				Rural Health Clinic (RHC) III		Cost	
		County					
		4.00					
2.00	City, State, Zip Code, County			LIVINGSTON		2.00	
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
11.00	Facility hours of operations (1)			Clinic		11.00	
		07:30	17:00	07:30	17:00		

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148505		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
				Rural Health Clinic (RHC) III		Cost	
		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
11.00	Facility hours of operations (1) Clinic	07:30	17:00	07:30	17:00	11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148505	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) III	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148515	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
			Rural Health Clinic (RHC) IV	Cost	
			1.00		
1.00	Clinic Address and Identification		837 E ORANGE STREET		
	Street	City	State	Zip Code	1.00
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County		HOOPESTON IL 60942		2.00
			1.00		
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award	Date	
			1.00	2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
			1.00		
10.00	Does this facility operate as other than an RHC or FOHC? 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)		08:30 18:00		11.00
			1.00		
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
			1.00		
			2.00		
			3.00		
			4.00		
			5.00		
14.00	Provider name, CCN number		HOOPESTON CLINIC		148515 14.00
			1.00		
			2.00		
			3.00		
			4.00		
			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 15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148515	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) IV	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	VERMILLION		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:30	17:00	08:30
				13:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148515		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
				Rural Health Clinic (RHC) IV		Cost	
		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
11.00	Facility hours of operations (1) Clinic	08:30	15:00	08:30	15:00	11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148515	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) IV	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148517		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
				Rural Health Clinic (RHC) V			
				1.00			
1.00	Clinic Address and Identification			1230 GEORGE ROCK DR		1.00	
	Street			City		State Zip Code	
				1.00		2.00 3.00	
2.00	City, State, Zip Code, County			FARMER CITY		IL61842 2.00	
				1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00	
				Grant Award		Date	
				1.00		2.00	
		Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00	
7.00	Appalachian Regional Commission			0		7.00	
8.00	Look-Alikes			0		8.00	
9.00	OTHER (SPECIFY)			0		9.00	
				1.00		2.00	
10.00	Does this facility operate as other than an RHC or FOHC? 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)			08:30		17:00 11.00	
		Clinic					
				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			FAMILY HEALTH CLINIC OF FARMER CITY		148517 14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 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 15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148517	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) V	
		County		
		4.00		
2.00	City, State, Zip Code, County			2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:30	17:00	08:30
				12:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148517		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
				Rural Health Clinic (RHC) V			
		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
11.00	Facility hours of operations (1) Clinic	08:30	15:00	08:30	15:00	11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141317 Component CCN: 148517	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) V	

		Saturday		
		from	to	
11.00	Facility hours of operations (1) Clinic	13.00	14.00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148516		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm	
				Rural Health Clinic (RHC) VI			
				1.00			
1.00	Clinic Address and Identification	Street		#7 DOCTORS PARK		1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00	City, State, Zip Code, County	GIBSON CITY		IL		60936 2.00	
				1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00	
				Grant Award		Date	
				1.00		2.00	
		Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00	
7.00	Appalachian Regional Commission			0		7.00	
8.00	Look-Alikes			0		8.00	
9.00	OTHER (SPECIFY)			0		9.00	
				1.00		2.00	
10.00	Does this facility operate as other than an RHC or FOHC? 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		08:00 05:00		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	FAMILY HEALTH CARE OF GIBSON CITY		148516		14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 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 15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141317 Component CCN: 148516	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) VI	
		County		
		4.00		
2.00	City, State, Zip Code, County			2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	05:00	08:00
			05:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141317 Component CCN: 148516	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) VI	

	Thursday		Friday				
	from	to	from	to			
	9.00	10.00	11.00	12.00			
11.00	Facility hours of operations (1) Clinic		08:00	05:00	08:00	05:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141317 Component CCN: 148516	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) VI	

		Saturday		
		from	to	
11.00	Facility hours of operations (1) Clinic	13.00	14.00	11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/26/2013 6:35 pm
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			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)		0.457574	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,295,996	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		258,120	5.00	
6.00	Medicaid charges		14,189,993	6.00	
7.00	Medicaid cost (line 1 times line 6)		6,492,972	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)		2,938,856	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		84,190	9.00	
10.00	Stand-alone SCHIP charges		183,889	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		84,143	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)		2,938,856	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	1,748,777	192,944	1,941,721	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	800,195	88,286	888,481	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	800,195	88,286	888,481	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,848,689	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		625,665	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		2,223,024	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,017,198	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,905,679	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,844,535	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 141317		Period: From 10/01/2011 To 09/30/2012		Worksheet A		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	NEW CAP REL COSTS-BLDG & FIXT		2,107,021			1,361,866	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0		775,756	775,756	2.00
4.00	00400	EMPLOYEE BENEFITS	221,213	6,676,384	6,897,597	399,244	7,296,841	4.00
5.01	00510	PATIENT ACCOUNTING & REGIST	887,125	479,826	1,366,951	0	1,366,951	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	2,399,131	5,292,131	7,691,262	-646,317	7,044,945	5.02
7.00	00700	OPERATION OF PLANT	492,629	1,104,623	1,597,252	3,614	1,600,866	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	107,778	39,860	147,638	0	147,638	8.00
9.00	00900	HOUSEKEEPING	266,643	66,023	332,666	0	332,666	9.00
10.00	01000	DIETARY	385,258	266,904	652,162	-351,969	300,193	10.00
11.00	01100	CAFETERIA	0	0	0	331,587	331,587	11.00
13.00	01300	NURSING ADMINISTRATION	453,308	120,587	573,895	0	573,895	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,983	16,983	0	16,983	14.00
15.00	01500	PHARMACY	421,584	137,962	559,546	0	559,546	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	340,081	53,486	393,567	0	393,567	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,618,479	347,249	2,965,728	-765,770	2,199,958	30.00
31.00	03100	INTENSIVE CARE UNIT	231,658	7,448	239,106	0	239,106	31.00
43.00	04300	NURSERY	0	0	0	175,559	175,559	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	171,506	171,506	44.00
46.00	04600	OTHER LONG TERM CARE	1,472,100	276,120	1,748,220	-194,564	1,553,656	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,017,341	902,849	1,920,190	0	1,920,190	50.00
51.00	05100	RECOVERY ROOM	229,499	29,612	259,111	0	259,111	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	602,136	602,136	52.00
53.00	05300	ANESTHESIOLOGY	1,037,006	105,772	1,142,778	0	1,142,778	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,311,532	2,370,900	3,682,432	-86,597	3,595,835	54.00
56.00	05600	RADIOISOTOPE	0	112,335	112,335	90,339	202,674	56.00
60.00	06000	LABORATORY	752,206	940,761	1,692,967	0	1,692,967	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	130,225	130,225	0	130,225	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	396,457	71,450	467,907	0	467,907	65.00
66.00	06600	PHYSICAL THERAPY	1,140,975	229,439	1,370,414	30,601	1,401,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,361	12,700	138,061	0	138,061	67.00
68.00	06800	SPEECH PATHOLOGY	80	61,590	61,670	0	61,670	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,308	23,308	0	23,308	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	786,379	786,379	0	786,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,333,956	2,333,956	0	2,333,956	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,112,173	1,112,173	0	1,112,173	73.00
73.01	07301	CARDIAC REHAB	85,485	15,207	100,692	0	100,692	73.01
73.02	07302	WOUND CARE	189,080	11,755	200,835	0	200,835	73.02
73.03	07303	SLEEP LAB	80,605	18,545	99,150	0	99,150	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	20,382	20,382	73.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - PAXTON CLINIC	2,273,616	1,055,114	3,328,730	123,134	3,451,864	88.00
88.01	08801	RHC II -ONARGA CLINIC	306,043	121,248	427,291	9,625	436,916	88.01
88.02	08802	RHC III - FORREST CLINIC	839,067	436,751	1,275,818	20,340	1,296,158	88.02
88.03	08803	RHC IV - HOOPESTON	370,764	178,315	549,079	-18,306	530,773	88.03
88.04	08804	RHC V - FARMER CITY	351,393	159,271	510,664	70,592	581,256	88.04
88.05	08805	RHC VI - GIBSON CITY	521,052	134,738	655,790	-4,931	650,859	88.05
90.00	09000	CLINIC	230,643	37,679	268,322	0	268,322	90.00
90.01	09001	GERI PSYCH CLINIC	134,576	168,833	303,409	0	303,409	90.01
90.02	09002	ORTHO CLINIC	1,193,315	510,436	1,703,751	0	1,703,751	90.02
91.00	09100	EMERGENCY	1,041,212	1,735,992	2,777,204	0	2,777,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,601,608	213,819	1,815,427	102,766	1,918,193	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,525,903	31,013,759	56,539,662	113,572	56,653,234	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.01	19201	GAH - MSO	210,094	110,713	320,807	0	320,807	192.01
192.02	19202	GAH FOUNDATION	12,976	101,580	114,556	0	114,556	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	33	33	0	33	194.00
194.01	07951	PHYSICIAN OFFICE	282,745	55,197	337,942	-93,350	244,592	194.01
194.02	07952	PHYSICIAN CLINICS	495,690	235,603	731,293	-20,222	711,071	194.02
194.03	07953	WELLNESS CENTER	40,708	9,294	50,002	0	50,002	194.03
194.06	07956	LASER CLINIC	6,943	19,244	26,187	0	26,187	194.06
194.07	07957	PAIN CLINIC	0	17,458	17,458	0	17,458	194.07
200.00		TOTAL (SUM OF LINES 118-199)	26,575,059	31,562,881	58,137,940	0	58,137,940	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141317

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

Worksheet A
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-67,580	1,294,286	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-52,113	723,643	2.00
4.00	00400	EMPLOYEE BENEFITS	-350,864	6,945,977	4.00
5.01	00510	PATIENT ACCOUNTING & REGIST	0	1,366,951	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,547,893	5,497,052	5.02
7.00	00700	OPERATION OF PLANT	0	1,600,866	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-11	147,627	8.00
9.00	00900	HOUSEKEEPING	0	332,666	9.00
10.00	01000	DIETARY	0	300,193	10.00
11.00	01100	CAFETERIA	-72,040	259,547	11.00
13.00	01300	NURSING ADMINISTRATION	0	573,895	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,983	14.00
15.00	01500	PHARMACY	0	559,546	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-194	393,373	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,199,958	30.00
31.00	03100	INTENSIVE CARE UNIT	0	239,106	31.00
43.00	04300	NURSERY	0	175,559	43.00
44.00	04400	SKILLED NURSING FACILITY	0	171,506	44.00
46.00	04600	OTHER LONG TERM CARE	0	1,553,656	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,920,190	50.00
51.00	05100	RECOVERY ROOM	0	259,111	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	602,136	52.00
53.00	05300	ANESTHESIOLOGY	-1,106,608	36,170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-858,887	2,736,948	54.00
56.00	05600	RADIOISOTOPE	0	202,674	56.00
60.00	06000	LABORATORY	-3,850	1,689,117	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	130,225	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	467,907	65.00
66.00	06600	PHYSICAL THERAPY	-107,509	1,293,506	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	138,061	67.00
68.00	06800	SPEECH PATHOLOGY	0	61,670	68.00
69.00	06900	ELECTROCARDIOLOGY	-18,730	4,578	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	786,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,333,956	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,112,173	73.00
73.01	07301	CARDIAC REHAB	0	100,692	73.01
73.02	07302	WOUND CARE	-20,192	180,643	73.02
73.03	07303	SLEEP LAB	0	99,150	73.03
73.04	03950	DIETARY EDUCATION	0	20,382	73.04
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - PAXTON CLINIC	-420,564	3,031,300	88.00
88.01	08801	RHC II -ONARGA CLINIC	-910	436,006	88.01
88.02	08802	RHC III - FORREST CLINIC	-102,678	1,193,480	88.02
88.03	08803	RHC IV - HOOPESTON	-15,600	515,173	88.03
88.04	08804	RHC V - FARMER CITY	-27,777	553,479	88.04
88.05	08805	RHC VI - GIBSON CITY	-23,013	627,846	88.05
90.00	09000	CLINIC	0	268,322	90.00
90.01	09001	GERI PSYCH CLINIC	-29,806	273,603	90.01
90.02	09002	ORTHO CLINIC	-1,119,752	583,999	90.02
91.00	09100	EMERGENCY	-1,088,871	1,688,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-1,008	1,917,185	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,036,450	49,616,784	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.01	19201	GAH - MSO	0	320,807	192.01
192.02	19202	GAH FOUNDATION	0	114,556	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	33	194.00
194.01	07951	PHYSICIAN OFFICE	0	244,592	194.01
194.02	07952	PHYSICIAN CLINICS	-2,600	708,471	194.02
194.03	07953	WELLNESS CENTER	0	50,002	194.03
194.06	07956	LASER CLINIC	0	26,187	194.06
194.07	07957	PAIN CLINIC	-400	17,058	194.07
200.00		TOTAL (SUM OF LINES 118-199)	-7,039,450	51,098,490	200.00

RECLASSIFICATIONS

Provider CCN: 141317

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

Worksheet A-6
Date/Time Prepared:
2/26/2013 6:35 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
A - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	287,276	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	48,264	2.00
3.00	RHC - PAXTON CLINIC	88.00	0	86,695	3.00
4.00	RHC II -ONARGA CLINIC	88.01	0	9,625	4.00
5.00	RHC III - FORREST CLINIC	88.02	0	39,689	5.00
6.00	AMBULANCE SERVICES	95.00	0	11,147	6.00
7.00	RHC V - FARMER CITY	88.04	0	14,995	7.00
	TOTALS		0	497,691	
B - CAFETERIA					
1.00	CAFETERIA	11.00	195,882	135,705	1.00
	TOTALS		195,882	135,705	
C - OBSTETRICS					
1.00	NURSERY	43.00	155,885	19,674	1.00
2.00	DELI VERY ROOM & LABOR ROOM	52.00	534,657	67,479	2.00
	TOTALS		690,542	87,153	
D - CLINIC BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	399,244	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	399,244	
E - ADM LONG TERM CARE FEES					
1.00	OTHER ADMINI STRATIVE AND GENERAL	5.02	0	23,058	1.00
	TOTALS		0	23,058	
F - SNF DI RECT CARE COST					
1.00	SKILLED NURSING FACILI TY	44.00	144,418	27,088	1.00
	TOTALS		144,418	27,088	
G - BOND AMORT COST					
1.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	4,975	1.00
	TOTALS		0	4,975	
H - MME DEP RE					
1.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	680,268	1.00
2.00	RADIOLOGY-DI AGNOSTIC	54.00	0	3,742	2.00
3.00	PHYSICAL THERAPY	66.00	0	30,601	3.00
4.00	RHC - PAXTON CLINIC	88.00	0	205,766	4.00
5.00	RHC V - FARMER CITY	88.04	0	37,715	5.00
6.00	RHC III - FORREST CLINIC	88.02	0	43,071	6.00
7.00	AMBULANCE SERVI CES	95.00	0	57,644	7.00
8.00	RHC V - FARMER CITY	88.04	0	49,247	8.00
	TOTALS		0	1,108,054	
I - CAPI TAL INSURANCE EXP					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	75,140	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	42,249	2.00
	TOTALS		0	117,389	
J - NUCLEAR MED TECH SALARY					
1.00	RADI OI SOTOPE	56.00	90,339	0	1.00
	TOTALS		90,339	0	
K - AMBULANCE BILLING & UTI LI TIES COST					
1.00	AMBULANCE SERVICES	95.00	37,589		1.00
2.00	OPERATION OF PLANT	7.00		3,614	2.00
	TOTALS		37,589	3,614	
L - PHYSICIAN COSTS					
1.00	ADULTS & PEDI ATRI CS	30.00	0	11,925	1.00
	TOTALS		0	11,925	
M - DIETARY EDUCATION					
1.00	DIETARY EDUCATION	73.04	0	20,382	1.00
	TOTALS		0	20,382	
500.00	Grand Total: Increases		1,158,770	2,436,278	500.00

RECLASSIFICATIONS

Provider CCN: 141317

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

Worksheet A-6
Date/Time Prepared:
2/26/2013 6:35 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - INTEREST RECLASS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	497,691	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		0	497,691			
B - CAFETERIA							
1.00	DIETARY	10.00	195,882	135,705	0		1.00
	TOTALS		195,882	135,705			
C - OBSTETRICS							
1.00	ADULTS & PEDIATRICS	30.00	690,542	87,153	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		690,542	87,153			
D - CLINIC BENEFITS							
1.00	RHC - PAXTON CLINIC	88.00	0	168,650	0		1.00
2.00	RHC III - FORREST CLINIC	88.02	0	62,420	0		2.00
3.00	RHC IV - HOOPESTON	88.03	0	18,306	0		3.00
4.00	RHC V - FARMER CITY	88.04	0	31,365	0		4.00
5.00	RHC VI - GIBSON CITY	88.05	0	4,931	0		5.00
6.00	PHYSICIAN OFFICE	194.01	0	93,350	0		6.00
7.00	PHYSICIAN CLINICS	194.02	0	20,222	0		7.00
	TOTALS		0	399,244			
E - ADM LONG TERM CARE FEES							
1.00	OTHER LONG TERM CARE	46.00	0	23,058	0		1.00
	TOTALS		0	23,058			
F - SNF DIRECT CARE COST							
1.00	OTHER LONG TERM CARE	46.00	144,418	27,088	0		1.00
	TOTALS		144,418	27,088			
G - BOND AMORT COST							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,975	14		1.00
	TOTALS		0	4,975			
H - MME DEPRE							
1.00	RHC - PAXTON CLINIC	88.00	0	677	9		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	4,781	0		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	674,810	11		3.00
4.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	427,786	11		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	1,108,054			
I - CAPITAL INSURANCE EXP							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	117,389	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	117,389			
J - NUCLEAR MED TECH SALARY							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	90,339	0	0		1.00
	TOTALS		90,339	0			
K - AMBULANCE BILLING & UTILITIES COST							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	37,589		0		1.00
2.00	AMBULANCE SERVICES	95.00		3,614	0		2.00
	TOTALS		37,589	3,614			
L - PHYSICIAN COSTS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	11,925	0		1.00
	TOTALS		0	11,925			
M - DIETARY EDUCATION							
1.00	DIETARY	10.00	0	20,382	0		1.00
	TOTALS		0	20,382			
500.00	Grand Total: Decreases		1,158,770	2,436,278			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141317

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/26/2013 6:35 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	344,036	0	0	0	1.00
2.00	Land Improvements	1,003,201	342,140	0	342,140	2.00
3.00	Buildings and Fixtures	23,806,775	512,056	0	512,056	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	17,849,111	1,292,856	0	1,292,856	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,003,123	2,147,052	0	2,147,052	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,003,123	2,147,052	0	2,147,052	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	NEW CAP REL COSTS-BLDG & FIXT	2,107,021	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,107,021	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	NEW CAP REL COSTS-BLDG & FIXT	26,008,208	0	26,008,208	0.576038	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	19,141,967	0	19,141,967	0.423962	2.00
3.00	Total (sum of lines 1-2)	45,150,175	0	45,150,175	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141317

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/26/2013 6:35 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	344,036	0		1.00		
2.00	Land Improvements	1,345,341	0		2.00		
3.00	Buildings and Fixtures	24,318,831	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	19,141,967	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	45,150,175	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	45,150,175	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,107,021		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	2,107,021		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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,065,411	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	632,518	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,697,929	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet A-7 Parts I-III Date/Time Prepared: 2/26/2013 6:35 pm
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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	NEW CAP REL COSTS-BLDG & FIXT	-841,290	75,140	0	-4,975	1,294,286	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	43,901	42,249	0	4,975	723,643	2.00
3.00	Total (sum of lines 1-2)	-797,389	117,389	0	0	2,017,929	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141317

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

Worksheet A-8

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)			0		0.00 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	-3,247,068	0		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		0		12.00
13.00 Laundry and linen service			0		0.00 13.00
14.00 Cafeteria-employees and guests			0		0.00 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			0		0.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00 19.00
20.00 Vending machines			0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	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	OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-47,750	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 32.00
33.00 CAH HIT ADJUSTMENT FOR DEPRECIATION	A	-27,526	0	OTHER ADMINISTRATIVE AND GENERAL	5.02 33.00
33.01 LI FELINE INCOME	B	-2,500	0	OTHER ADMINISTRATIVE AND GENERAL	5.02 33.01
33.02 A&G MISC REV	B	-773	0	OTHER ADMINISTRATIVE AND GENERAL	5.02 33.02
33.03 DR BARK DIRECTOR FEES	B	-46,503	0	RHC - PAXTON CLINIC	88.00 33.03
33.04			0		0.00 33.04
33.05 CAFE MISC REV	B	-72,040	0	CAFETERIA	11.00 33.05
33.06 LAUNDRY MISC REV	B	-11	0	LAUNDRY & LINEN SERVICE	8.00 33.06
33.07 MED RECORDS MISC REV	B	-194	0	MEDICAL RECORDS & LIBRARY	16.00 33.07
33.08 RENTAL INC - OPC	B	-41,610	0	NEW CAP REL COSTS-BLDG & FIXT	1.00 33.08
33.09 INVEST INCOME - B&F	B	-25,970	0	NEW CAP REL COSTS-BLDG & FIXT	1.00 33.09
33.10 INVEST INCOME - MME	B	-4,363	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 33.10
33.11 INVEST INCOME - PAXTON	B	-7,837	0	RHC - PAXTON CLINIC	88.00 33.11
34.00 INVEST INCOME - ONARGA	B	-870	0	RHC II -ONARGA CLINIC	88.01 34.00
35.00 INVEST INCOME - FORREST	B	-3,588	0	RHC III - FORREST CLINIC	88.02 35.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141317

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

Worksheet A-8

Date/Time Prepared:
2/26/2013 6:35 pm

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
36.00 INVEST INCOME - AMBULANCE	B	-1,008	AMBULANCE SERVICES	95.00 36.00
37.00 INVEST INCOME - FARMER CITY	B	-1,356	RHC V - FARMER CITY	88.04 37.00
38.00		0		0.00 38.00
38.01 SCHOOL NURSING INCOME	B	-68,250	OTHER ADMINISTRATIVE AND GENERAL	5.02 38.01
39.00		0		0.00 39.00
40.00 INTERNALLY ALLOCATED RENT EXP - RHC	A	-107,300	RHC - PAXTON CLINIC	88.00 40.00
41.00 INTERNALLY ALLOCATED RENT EXP - RHC	A	-33,400	RHC III - FORREST CLINIC	88.02 41.00
42.00 INTERNALLY ALLOCATED RENT EXP - RHC	A	-15,600	RHC IV - HOOPESTON	88.03 42.00
43.00 INTERNALLY ALLOCATED RENT EXP - RHC	A	-20,628	RHC V - FARMER CITY	88.04 43.00
44.00 INTERNALLY ALLOCATED RENT EXP - RHC	A	-19,200	RHC VI - GIBSON CITY	88.05 44.00
45.00 INTERNALLY ALLOCATED RENT EXP - ORTH	A	-35,330	ORTHO CLINIC	90.02 45.00
45.01 INTERNALLY ALLOCATED RENT EXP - PO	A	-2,600	PHYSICIAN CLINICS	194.02 45.01
45.02 INTERNALLY ALLOCATED RENT EXP - CLIN	A	-400	PAIN CLINIC	194.07 45.02
45.03 CRNA NONSALARY EXPEN	A	-34,801	ANESTHESIOLOGY	53.00 45.03
45.04 LOBBYING DUES	A	-15,886	OTHER ADMINISTRATIVE AND GENERAL	5.02 45.04
45.05 STATE PROVIDER TAX EXP	A	-258,120	OTHER ADMINISTRATIVE AND GENERAL	5.02 45.05
45.06 CRNA SALARIES	A	-1,037,006	ANESTHESIOLOGY	53.00 45.06
45.07 CRNA BENEFITS	A	-175,203	EMPLOYEE BENEFITS	4.00 45.07
45.08 PHYSICIAN RECRUITMENT	A	-21,262	OTHER ADMINISTRATIVE AND GENERAL	5.02 45.08
45.09 PUBLIC RELATIONS OFFSET	A	-431,269	OTHER ADMINISTRATIVE AND GENERAL	5.02 45.09
45.10 GIBSON PHO EXP	A	-529,981	OTHER ADMINISTRATIVE AND GENERAL	5.02 45.10
45.13 ONARGA LAB SRVCS COST	A	-40	RHC II -ONARGA CLINIC	88.01 45.13
45.14 PAXTON LAB SRVC COST	A	-37,708	RHC - PAXTON CLINIC	88.00 45.14
45.15 FORREST LAB SERVICE COST	A	-7,911	RHC III - FORREST CLINIC	88.02 45.15
45.16		0		0.00 45.16
45.17 MISC DONATIONS (COMM ED)	A	-192,326	OTHER ADMINISTRATIVE AND GENERAL	5.02 45.17
45.18 EXCESS PHYSICIAN COMP ADJ	A	-192,864	RHC - PAXTON CLINIC	88.00 45.18
45.19 PT B PHYSICIAN BENEFITS	A	-175,661	EMPLOYEE BENEFITS	4.00 45.19
45.20 PAXTON DRS HOSP VISIT	A	-28,352	RHC - PAXTON CLINIC	88.00 45.20
45.21 FARMER CITY DRS HOSP VISIT	A	-5,793	RHC V - FARMER CITY	88.04 45.21
45.22 GIBSON CITY DRS HOSP VISIT	A	-3,813	RHC VI - GIBSON CITY	88.05 45.22
45.23 FORREST DRS HOSP VISIT	A	-57,779	RHC III - FORREST CLINIC	88.02 45.23
45.24		0		0.00 45.24
45.25		0		0.00 45.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,039,450		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141317

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

Worksheet A-8

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW 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 - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	9	32.00
33.00	CAH HIT ADJUSTMENT FOR DEPRECIATION	0	33.00
33.01	LIFELINE INCOME	0	33.01
33.02	A&G MISC REV	0	33.02
33.03	DR BARK DIRECTOR FEES	0	33.03
33.04		0	33.04
33.05	CAFE MISC REV	0	33.05
33.06	LAUNDRY MISC REV	0	33.06
33.07	MED RECORDS MISC REV	0	33.07
33.08	RENTAL INC - OPC	9	33.08
33.09	INVEST INCOME - B&F	11	33.09
33.10	INVEST INCOME - MME	11	33.10
33.11	INVEST INCOME - PAXTON	0	33.11
34.00	INVEST INCOME - ONARGA	0	34.00
35.00	INVEST INCOME - FORREST	0	35.00
36.00	INVEST INCOME - AMBULANCE	0	36.00
37.00	INVEST INCOME - FARMER CITY	0	37.00
38.00		0	38.00
38.01	SCHOOL NURSING INCOME	0	38.01
39.00		0	39.00
40.00	INTERNALLY ALLOCATED RENT EXP - RHC	0	40.00
41.00	INTERNALLY ALLOCATED RENT EXP - RHC	0	41.00
42.00	INTERNALLY ALLOCATED RENT EXP - RHC	0	42.00
43.00	INTERNALLY ALLOCATED RENT EXP - RHC	0	43.00
44.00	INTERNALLY ALLOCATED RENT EXP - RHC	0	44.00
45.00	INTERNALLY ALLOCATED RENT EXP - ORTH	0	45.00
45.01	INTERNALLY ALLOCATED RENT EXP - PO	0	45.01
45.02	INTERNALLY ALLOCATED RENT EXP - CLIN	0	45.02
45.03	CRNA NONSALARY EXPEN	0	45.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 141317

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

Worksheet A-8

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
45.04	LOBBYING DUES	0	45.04
45.05	STATE PROVIDER TAX EXP	0	45.05
45.06	CRNA SALARIES	0	45.06
45.07	CRNA BENEFITS	0	45.07
45.08	PHYSICIAN RECRUITMENT	0	45.08
45.09	PUBLIC RELATIONS OFFSET	0	45.09
45.10	GIBSON PHO EXP	0	45.10
45.13	ONARGA LAB SRVCS COST	0	45.13
45.14	PAXTON LAB SRVC COST	0	45.14
45.15	FORREST LAB SERVICE COST	0	45.15
45.16		0	45.16
45.17	MISC DONATIONS (COMM ED)	0	45.17
45.18	EXCESS PHYSICIAN COMP ADJ	0	45.18
45.19	PT B PHYSICIAN BENEFITS	0	45.19
45.20	PAXTON DRS HOSP VISIT	0	45.20
45.21	FARMER CITY DRS HOSP VISIT	0	45.21
45.22	GIBSON CITY DRS HOSP VISIT	0	45.22
45.23	FORREST DRS HOSP VISIT	0	45.23
45.24		0	45.24
45.25		0	45.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141317

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

Worksheet A-8-2

Date/Time Prepared:
2/26/2013 6:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	44.00	SKILLED NURSING FACILITY	21,900	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	18,730	18,730	2.00
3.00	73.01	CARDIAC REHAB	8,250	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	677,400	677,400	4.00
5.00	91.00	EMERGENCY	1,617,757	1,088,871	5.00
6.00	60.00	LABORATORY	3,850	3,850	6.00
7.00	53.00	ANESTHESIOLOGY	47,700	0	7.00
8.00	66.00	PHYSICAL THERAPY	107,509	107,509	8.00
9.00	73.03	SLEEP LAB	12,750	0	9.00
10.00	90.01	GERI PSYCH CLINIC	29,806	29,806	10.00
11.00	90.02	ORTHO CLINIC	185,441	185,441	11.00
12.00	90.02	ORTHO CLINIC	898,981	898,981	12.00
13.00	73.02	WOUND CARE	20,192	20,192	13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	120,544	120,544	14.00
15.00	54.00	RADIOLOGY-DIAGNOSTIC	60,943	60,943	15.00
16.00	53.00	ANESTHESIOLOGY	34,801	34,801	16.00
200.00			3,866,554	3,247,068	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141317

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

Worksheet A-8-2

Date/Time Prepared:
2/26/2013 6:35 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	21,900	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	8,250	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	528,886	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	47,700	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	12,750	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
15.00	0	0	0	0	0	15.00
16.00	0	0	0	0	0	16.00
200.00	619,486					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141317

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

Worksheet A-8-2

Date/Time Prepared:
2/26/2013 6:35 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 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
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
15.00	0	0	0	0	0	15.00
16.00	0	0	0	0	0	16.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141317

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

Worksheet A-8-2

Date/Time Prepared:
2/26/2013 6:35 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	18,730	2.00
3.00	0	0	3.00
4.00	0	677,400	4.00
5.00	0	1,088,871	5.00
6.00	0	3,850	6.00
7.00	0	0	7.00
8.00	0	107,509	8.00
9.00	0	0	9.00
10.00	0	29,806	10.00
11.00	0	185,441	11.00
12.00	0	898,981	12.00
13.00	0	20,192	13.00
14.00	0	120,544	14.00
15.00	0	60,943	15.00
16.00	0	34,801	16.00
200.00	0	3,247,068	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141317

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1,294,286	1,294,286				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	723,643		723,643			2.00
4.00 00400 EMPLOYEE BENEFITS	6,945,977	6,458	0	6,952,435		4.00
5.01 00510 PATIENT ACCOUNTING & REGIST	1,366,951	5,228	234	254,053	1,626,466	5.01
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL	5,497,052	143,425	206,873	676,296	6,523,646	5.02
7.00 00700 OPERATION OF PLANT	1,600,866	359,756	784	141,078	2,102,484	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	147,627	17,183	531	30,865	196,206	8.00
9.00 00900 HOUSEKEEPING	332,666	5,478	0	76,361	414,505	9.00
10.00 01000 DIETARY	300,193	25,100	5,518	54,233	385,044	10.00
11.00 01100 CAFETERIA	259,547	7,967	0	56,096	323,610	11.00
13.00 01300 NURSING ADMINISTRATION	573,895	2,979	0	129,817	706,691	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	16,983	7,037	0	0	24,020	14.00
15.00 01500 PHARMACY	559,546	13,245	0	120,732	693,523	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	393,373	10,306	80	97,392	501,151	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	2,199,958	132,389	78,110	552,118	2,962,575	30.00
31.00 03100 INTENSIVE CARE UNIT	239,106	9,696	0	66,342	315,144	31.00
43.00 04300 NURSERY	175,559	3,189	0	44,642	223,390	43.00
44.00 04400 SKILLED NURSING FACILITY	171,506	11,446	0	41,358	224,310	44.00
46.00 04600 OTHER LONG TERM CARE	1,553,656	122,283	11,163	380,219	2,067,321	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,920,190	61,287	143,823	291,344	2,416,644	50.00
51.00 05100 RECOVERY ROOM	259,111	12,625	328	65,723	337,787	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	602,136	10,796	0	153,114	766,046	52.00
53.00 05300 ANESTHESIOLOGY	36,170	980	15,526	0	52,676	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,736,948	72,242	109,513	315,202	3,233,905	54.00
56.00 05600 RADIOISOTOPE	202,674	6,587	0	25,871	235,132	56.00
60.00 06000 LABORATORY	1,689,117	18,763	18,020	215,415	1,941,315	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	130,225	1,539	0	0	131,764	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	467,907	4,508	7,142	113,537	593,094	65.00
66.00 06600 PHYSICAL THERAPY	1,293,506	106,449	37,770	326,750	1,764,475	66.00
67.00 06700 OCCUPATIONAL THERAPY	138,061	2,249	50	35,901	176,261	67.00
68.00 06800 SPEECH PATHOLOGY	61,670	2,249	0	23	63,942	68.00
69.00 06900 ELECTROCARDIOLOGY	4,578	0	0	0	4,578	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	786,379	0	0	0	786,379	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,333,956	0	0	0	2,333,956	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,112,173	0	0	0	1,112,173	73.00
73.01 07301 CARDIAC REHAB	100,692	10,106	6,149	24,481	141,428	73.01
73.02 07302 WOUND CARE	180,643	6,687	0	48,366	235,696	73.02
73.03 07303 SLEEP LAB	99,150	0	824	23,083	123,057	73.03
73.04 03950 DIETARY EDUCATION	20,382	0	0	0	20,382	73.04
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RHC - PAXTON CLINIC	3,031,300	0	11,633	651,114	3,694,047	88.00
88.01 08801 RHC II - ONARGA CLINIC	436,006	0	0	87,644	523,650	88.01
88.02 08802 RHC III - FORREST CLINIC	1,193,480	0	11,651	240,290	1,445,421	88.02
88.03 08803 RHC IV - HOOPESTON	515,173	0	10,638	106,179	631,990	88.03
88.04 08804 RHC V - FARMER CITY	553,479	0	3,917	100,631	658,027	88.04
88.05 08805 RHC VI - GIBSON CITY	627,846	0	0	149,218	777,064	88.05
90.00 09000 CLINIC	268,322	23,701	3,008	66,051	361,082	90.00
90.01 09001 GERI PSYCH CLINIC	273,603	0	0	38,540	312,143	90.01
90.02 09002 ORTHO CLINIC	583,999	0	0	84,291	668,290	90.02
91.00 09100 EMERGENCY	1,688,333	66,964	38,105	298,180	2,091,582	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	1,917,185	0	2,253	469,430	2,388,868	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	49,616,784	1,290,897	723,643	6,651,980	49,312,940	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,389	0	0	3,389	190.00
192.01 19201 GAH - MSO	320,807	0	0	60,166	380,973	192.01
192.02 19202 GAH FOUNDATION	114,556	0	0	3,716	118,272	192.02
194.00 07950 HOSPITAL ASSOC SRVCS	33	0	0	0	33	194.00
194.01 07951 PHYSICIAN OFFICE	244,592	0	0	80,972	325,564	194.01
194.02 07952 PHYSICIAN CLINICS	708,471	0	0	141,955	850,426	194.02
194.03 07953 WELLNESS CENTER	50,002	0	0	11,658	61,660	194.03
194.06 07956 LASER CLINIC	26,187	0	0	1,988	28,175	194.06
194.07 07957 PAIN CLINIC	17,058	0	0	0	17,058	194.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141317

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
200.00 Cross Foot Adjustments						0 200.00
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	51,098,490	1,294,286	723,643	6,952,435	51,098,490	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141317

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		PATIENT ACCOUNTING & REGIST	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5A.01	5.02	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PATIENT ACCOUNTING & REGIST	1,626,466				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	300,403	6,824,049	6,824,049		5.02
7.00	00700	OPERATION OF PLANT	96,815	2,199,299	338,980	2,538,279	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,035	205,241	31,634	38,807	275,682
9.00	00900	HOUSEKEEPING	19,087	433,592	66,830	12,371	21,505
10.00	01000	DIETARY	17,731	402,775	62,080	56,686	2,459
11.00	01100	CAFETERIA	14,902	338,512	52,175	17,992	5,249
13.00	01300	NURSING ADMINISTRATION	32,542	739,233	113,939	6,727	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,106	25,126	3,873	15,893	0
15.00	01500	PHARMACY	31,935	725,458	111,816	29,912	0
16.00	01600	MEDICAL RECORDS & LIBRARY	23,077	524,228	80,800	23,275	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	136,421	3,098,996	477,651	298,985	55,306
31.00	03100	INTENSIVE CARE UNIT	14,512	329,656	50,810	21,898	0
43.00	04300	NURSERY	10,287	233,677	36,017	7,201	1,287
44.00	04400	SKILLED NURSING FACILITY	0	224,310	34,573	25,849	14,594
46.00	04600	OTHER LONG TERM CARE	0	2,067,321	318,638	276,161	96,069
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	111,282	2,527,926	389,632	138,408	29,853
51.00	05100	RECOVERY ROOM	15,554	353,341	54,461	28,512	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,275	801,321	123,508	24,381	7,688
53.00	05300	ANESTHESIOLOGY	2,426	55,102	8,493	2,212	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,915	3,382,820	521,397	163,150	11,032
56.00	05600	RADIOISOTOPE	10,827	245,959	27,910	14,877	0
60.00	06000	LABORATORY	89,394	2,030,709	312,995	42,374	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,067	137,831	21,244	3,477	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	27,311	620,405	95,624	10,181	0
66.00	06600	PHYSICAL THERAPY	81,251	1,845,726	284,484	240,402	12,766
67.00	06700	OCCUPATIONAL THERAPY	8,116	184,377	28,418	5,079	0
68.00	06800	SPEECH PATHOLOGY	2,944	66,886	10,309	5,079	0
69.00	06900	ELECTROCARDIOLOGY	211	4,789	738	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,211	822,590	126,787	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	107,474	2,441,430	376,300	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	51,213	1,163,386	179,314	0	0
73.01	07301	CARDIAC REHAB	6,512	147,940	22,802	22,823	0
73.02	07302	WOUND CARE	10,853	246,549	38,001	15,103	0
73.03	07303	SLEEP LAB	5,667	128,724	19,840	0	0
73.04	03950	DIETARY EDUCATION	939	21,321	3,286	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - PAXTON CLINIC	0	3,694,047	569,353	350,887	0
88.01	08801	RHC II - ONARGA CLINIC	0	523,650	80,711	26,842	0
88.02	08802	RHC III - FORREST CLINIC	0	1,445,421	222,784	68,087	0
88.03	08803	RHC IV - HOOPESTON	0	631,990	97,409	46,256	0
88.04	08804	RHC V - FARMER CITY	0	658,027	101,422	48,762	0
88.05	08805	RHC VI - GIBSON CITY	0	777,064	119,770	0	0
90.00	09000	CLINIC	16,627	377,709	58,217	53,526	0
90.01	09001	GERI PSYCH CLINIC	14,374	326,517	50,326	65,739	0
90.02	09002	ORTHO CLINIC	30,773	699,063	107,747	0	0
91.00	09100	EMERGENCY	96,313	2,187,895	337,222	151,231	17,874
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,388,868	368,199	171,481	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,624,382	49,310,856	6,548,519	2,530,626	275,682
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,389	522	7,653	0
192.01	19201	GAH - MSO	0	380,973	58,720	0	0
192.02	19202	GAH FOUNDATION	0	118,272	18,229	0	0
194.00	07950	HOSPITAL ASSOC SRVCS	2	35	5	0	0
194.01	07951	PHYSICIAN OFFICE	0	325,564	50,180	0	0
194.02	07952	PHYSICIAN CLINICS	0	850,426	131,077	0	0
194.03	07953	WELLNESS CENTER	0	61,660	9,504	0	0
194.06	07956	LASER CLINIC	1,297	29,472	4,543	0	0
194.07	07957	PAIN CLINIC	785	17,843	2,750	0	0
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,626,466	51,098,490	6,824,049	2,538,279	275,682

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 141317		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part I Date/Time Prepared: 2/26/2013 6:35 pm	
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PATIENT ACCOUNTING & REGIST					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	534,298				9.00
10.00	01000	DIETARY	17,722	541,722			10.00
11.00	01100	CAFETERIA	5,625	0	419,553		11.00
13.00	01300	NURSING ADMINISTRATION	2,103	0	4,951	866,953	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,969	0	0	0	14.00
15.00	01500	PHARMACY	9,351	0	2,792	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,276	0	13,252	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	93,470	119,585	53,333	226,446	1,400
31.00	03100	INTENSIVE CARE UNIT	6,846	802	4,408	18,746	5
43.00	04300	NURSERY	2,251	0	3,218	13,665	0
44.00	04400	SKILLED NURSING FACILITY	8,081	41,334	5,069	21,529	0
46.00	04600	OTHER LONG TERM CARE	86,336	380,001	46,604	197,916	496
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	43,270	0	31,383	133,280	4,704
51.00	05100	RECOVERY ROOM	8,914	0	6,127	25,995	197
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,622	0	11,034	46,865	0
53.00	05300	ANESTHESIOLOGY	692	0	7,214	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,006	0	35,967	0	156
56.00	05600	RADIOISOTOPE	4,651	0	6,832	0	14
60.00	06000	LABORATORY	13,247	0	29,061	0	470
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,087	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,183	0	11,431	48,551	18
66.00	06600	PHYSICAL THERAPY	75,157	0	26,387	0	31
67.00	06700	OCCUPATIONAL THERAPY	1,588	0	2,718	0	0
68.00	06800	SPEECH PATHOLOGY	1,588	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	9
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,670
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	30,339
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	CARDIAC REHAB	7,135	0	2,219	9,424	11
73.02	07302	WOUND CARE	4,722	0	2,174	9,229	33
73.03	07303	SLEEP LAB	0	0	1,837	7,792	2
73.04	03950	DIETARY EDUCATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - PAXTON CLINIC	0	0	0	0	50
88.01	08801	RHC II - ONARGA CLINIC	0	0	0	0	19
88.02	08802	RHC III - FORREST CLINIC	0	0	0	0	80
88.03	08803	RHC IV - HOOPESTON	0	0	0	0	27
88.04	08804	RHC V - FARMER CITY	0	0	0	0	16
88.05	08805	RHC VI - GIBSON CITY	0	0	0	0	0
90.00	09000	CLINIC	16,734	0	7,317	31,067	125
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	5
90.02	09002	ORTHO CLINIC	0	0	18,894	0	0
91.00	09100	EMERGENCY	47,279	0	17,998	76,448	618
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	67,333	0	115
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	531,905	541,722	419,553	866,953	49,680
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,393	0	0	0	0
192.01	19201	GAH - MSO	0	0	0	0	11
192.02	19202	GAH FOUNDATION	0	0	0	0	0
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	0	0
194.01	07951	PHYSICIAN OFFICE	0	0	0	0	134
194.02	07952	PHYSICIAN CLINICS	0	0	0	0	30
194.03	07953	WELLNESS CENTER	0	0	0	0	6
194.06	07956	LASER CLINIC	0	0	0	0	0
194.07	07957	PAIN CLINIC	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	534,298	541,722	419,553	866,953	49,861

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 141317		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part I Date/Time Prepared: 2/26/2013 6:35 pm	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PATIENT ACCOUNTING & REGIST						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	879,375					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	648,855				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	967	291,603	4,717,742	-63,698	4,654,044	30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,753	456,924	0	456,924	31.00
43.00	04300	NURSERY	0	0	297,316	0	297,316	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	375,339	0	375,339	44.00
46.00	04600	OTHER LONG TERM CARE	67	0	3,469,609	0	3,469,609	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,115	113,394	3,415,965	0	3,415,965	50.00
51.00	05100	RECOVERY ROOM	0	0	477,547	0	477,547	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,022,419	0	1,022,419	52.00
53.00	05300	ANESTHESIOLOGY	12,041	0	85,754	0	85,754	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,143	190,264	4,357,935	0	4,357,935	54.00
56.00	05600	RADIOISOTOPE	80	0	310,323	0	310,323	56.00
60.00	06000	LABORATORY	42	0	2,428,898	0	2,428,898	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	163,639	0	163,639	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	63,698	63,698	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,968	795,361	0	795,361	65.00
66.00	06600	PHYSICAL THERAPY	87	0	2,485,040	0	2,485,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	222,180	0	222,180	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	83,862	0	83,862	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,536	0	5,536	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	960,047	0	960,047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	2,848,069	0	2,848,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	808,864	0	2,151,564	0	2,151,564	73.00
73.01	07301	CARDIAC REHAB	0	0	212,354	0	212,354	73.01
73.02	07302	WOUND CARE	57	0	315,868	0	315,868	73.02
73.03	07303	SLEEP LAB	0	0	158,195	0	158,195	73.03
73.04	03950	DIETARY EDUCATION	0	0	24,607	0	24,607	73.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - PAXTON CLINIC	12,196	0	4,626,533	0	4,626,533	88.00
88.01	08801	RHC II - ONARGA CLINIC	2,897	0	634,119	0	634,119	88.01
88.02	08802	RHC III - FORREST CLINIC	7,881	0	1,744,253	0	1,744,253	88.02
88.03	08803	RHC IV - HOOPESTON	3,219	0	778,901	0	778,901	88.03
88.04	08804	RHC V - FARMER CITY	1,974	0	810,201	0	810,201	88.04
88.05	08805	RHC VI - GIBSON CITY	3,260	0	900,094	0	900,094	88.05
90.00	09000	CLINIC	709	0	545,404	0	545,404	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	442,587	0	442,587	90.01
90.02	09002	ORTHO CLINIC	12,577	0	838,281	0	838,281	90.02
91.00	09100	EMERGENCY	1,073	23,873	2,861,511	0	2,861,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,906	0	3,000,902	0	3,000,902	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	879,155	648,855	49,024,879	0	49,024,879	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	13,957	0	13,957	190.00
192.01	19201	GAH - MSO	0	0	439,704	0	439,704	192.01
192.02	19202	GAH FOUNDATION	0	0	136,501	0	136,501	192.02
194.00	07950	HOSPITAL ASSOC SVCS	0	0	40	0	40	194.00
194.01	07951	PHYSICIAN OFFICE	0	0	375,878	0	375,878	194.01
194.02	07952	PHYSICIAN CLINICS	220	0	981,753	0	981,753	194.02
194.03	07953	WELLNESS CENTER	0	0	71,170	0	71,170	194.03
194.06	07956	LASER CLINIC	0	0	34,015	0	34,015	194.06
194.07	07957	PAIN CLINIC	0	0	20,593	0	20,593	194.07
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141317

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
202.00	TOTAL (sum lines 118-201)	879,375	648,855	51,098,490	25.00	51,098,490	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/26/2013 6:35 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS	0	6,458	0	6,458
5.01	00510	PATIENT ACCOUNTING & REGIST	0	5,228	234	5,462
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	143,425	206,873	350,298
7.00	00700	OPERATION OF PLANT	0	359,756	784	360,540
8.00	00800	LAUNDRY & LINEN SERVICE	0	17,183	531	17,714
9.00	00900	HOUSEKEEPING	0	5,478	0	5,478
10.00	01000	DIETARY	0	25,100	5,518	30,618
11.00	01100	CAFETERIA	0	7,967	0	7,967
13.00	01300	NURSING ADMINISTRATION	0	2,979	0	2,979
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,037	0	7,037
15.00	01500	PHARMACY	0	13,245	0	13,245
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,306	80	10,386
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	132,389	78,110	210,499
31.00	03100	INTENSIVE CARE UNIT	0	9,696	0	9,696
43.00	04300	NURSERY	0	3,189	0	3,189
44.00	04400	SKILLED NURSING FACILITY	0	11,446	0	11,446
46.00	04600	OTHER LONG TERM CARE	0	122,283	11,163	133,446
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	61,287	143,823	205,110
51.00	05100	RECOVERY ROOM	0	12,625	328	12,953
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,796	0	10,796
53.00	05300	ANESTHESIOLOGY	0	980	15,526	16,506
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,242	109,513	181,755
56.00	05600	RADIO SOTOPE	0	6,587	0	6,587
60.00	06000	LABORATORY	0	18,763	18,020	36,783
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,539	0	1,539
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	4,508	7,142	11,650
66.00	06600	PHYSICAL THERAPY	0	106,449	37,770	144,219
67.00	06700	OCCUPATIONAL THERAPY	0	2,249	50	2,299
68.00	06800	SPEECH PATHOLOGY	0	2,249	0	2,249
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
73.01	07301	CARDIAC REHAB	0	10,106	6,149	16,255
73.02	07302	WOUND CARE	0	6,687	0	6,687
73.03	07303	SLEEP LAB	0	0	824	824
73.04	03950	DIETARY EDUCATION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	11,633	11,633
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	0
88.02	08802	RHC III - FORREST CLINIC	0	0	11,651	11,651
88.03	08803	RHC IV - HOOPESTON	0	0	10,638	10,638
88.04	08804	RHC V - FARMER CITY	0	0	3,917	3,917
88.05	08805	RHC VI - GIBSON CITY	0	0	0	0
90.00	09000	CLINIC	0	23,701	3,008	26,709
90.01	09001	GERI PSYCH CLINIC	0	0	0	0
90.02	09002	ORTHO CLINIC	0	0	0	0
91.00	09100	EMERGENCY	0	66,964	38,105	105,069
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	2,253	2,253
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,290,897	723,643	2,014,540
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,389	0	3,389
192.01	19201	GAH - MSO	0	0	0	0
192.02	19202	GAH FOUNDATION	0	0	0	0
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	0
194.01	07951	PHYSICIAN OFFICE	0	0	0	0
194.02	07952	PHYSICIAN CLINICS	0	0	0	0
194.03	07953	WELLNESS CENTER	0	0	0	0
194.06	07956	LASER CLINIC	0	0	0	0
194.07	07957	PAIN CLINIC	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141317

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

Worksheet B
Part II
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,294,286	723,643	2,017,929	6,458	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/26/2013 6:35 pm		
Cost Center Description			PATIENT ACCOUNTING & REGISTRY 5.01	OTHER ADMINISTRATIVE AND GENERAL 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PATIENT ACCOUNTING & REGISTRY	5,698				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,060	351,989			5.02
7.00	00700	OPERATION OF PLANT	338	17,484	378,493		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32	1,632	5,787	25,194	8.00
9.00	00900	HOUSEKEEPING	67	3,447	1,845	1,965	12,873
10.00	01000	DIETARY	62	3,202	8,453	225	427
11.00	01100	CAFETERIA	52	2,691	2,683	480	136
13.00	01300	NURSING ADMINISTRATION	114	5,877	1,003	0	51
14.00	01400	CENTRAL SERVICES & SUPPLY	4	200	2,370	0	120
15.00	01500	PHARMACY	112	5,767	4,460	0	225
16.00	01600	MEDICAL RECORDS & LIBRARY	81	4,168	3,471	0	175
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	477	24,637	44,583	5,054	2,250
31.00	03100	INTENSIVE CARE UNIT	51	2,621	3,265	0	165
43.00	04300	NURSERY	36	1,858	1,074	118	54
44.00	04400	SKILLED NURSING FACILITY	0	1,783	3,854	1,334	195
46.00	04600	OTHER LONG TERM CARE	0	16,435	41,180	8,779	2,080
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	389	20,097	20,639	2,728	1,043
51.00	05100	RECOVERY ROOM	54	2,809	4,252	0	215
52.00	05200	DELIVERY ROOM & LABOR ROOM	123	6,371	3,636	703	184
53.00	05300	ANESTHESIOLOGY	8	438	330	0	17
54.00	05400	RADIOLOGY-DIAGNOSTIC	521	26,893	24,328	1,008	1,229
56.00	05600	RADIOISOTOPE	38	1,955	2,218	0	112
60.00	06000	LABORATORY	313	16,144	6,318	0	319
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21	1,096	518	0	26
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	95	4,932	1,518	0	77
66.00	06600	PHYSICAL THERAPY	284	14,674	35,847	1,167	1,811
67.00	06700	OCCUPATIONAL THERAPY	28	1,466	757	0	38
68.00	06800	SPEECH PATHOLOGY	10	532	757	0	38
69.00	06900	ELECTROCARDIOLOGY	1	38	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	127	6,540	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	376	19,409	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	179	9,249	0	0	0
73.01	07301	CARDIAC REHAB	23	1,176	3,403	0	172
73.02	07302	WOUND CARE	38	1,960	2,252	0	114
73.03	07303	SLEEP LAB	20	1,023	0	0	0
73.04	03950	DIETARY EDUCATION	3	170	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - PAXTON CLINIC	0	29,374	52,323	0	0
88.01	08801	RHC II - ONARGA CLINIC	0	4,163	4,002	0	0
88.02	08802	RHC III - FORREST CLINIC	0	11,491	10,153	0	0
88.03	08803	RHC IV - HOOPESTON	0	5,024	6,897	0	0
88.04	08804	RHC V - FARMER CITY	0	5,231	7,271	0	0
88.05	08805	RHC VI - GIBSON CITY	0	6,178	0	0	0
90.00	09000	CLINIC	58	3,003	7,981	0	403
90.01	09001	GERI PSYCH CLINIC	50	2,596	9,803	0	0
90.02	09002	ORTHO CLINIC	108	5,558	0	0	0
91.00	09100	EMERGENCY	337	17,394	22,551	1,633	1,139
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	18,992	25,570	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,690	337,778	377,352	25,194	12,815
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27	1,141	0	58
192.01	19201	GAH - MSO	0	3,029	0	0	0
192.02	19202	GAH FOUNDATION	0	940	0	0	0
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	0	0
194.01	07951	PHYSICIAN OFFICE	0	2,588	0	0	0
194.02	07952	PHYSICIAN CLINICS	0	6,761	0	0	0
194.03	07953	WELLNESS CENTER	0	490	0	0	0
194.06	07956	LASER CLINIC	5	234	0	0	0
194.07	07957	PAIN CLINIC	3	142	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	5,698	351,989	378,493	25,194	12,873

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141317

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

Worksheet B
Part II
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	43,037					10.00
11.00	01100	0	14,061				11.00
13.00	01300	0	166	10,311			13.00
14.00	01400	0	0	0	9,731		14.00
15.00	01500	0	94	0	9	24,024	15.00
16.00	01600	0	444	0	5	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,500	1,787	2,693	273	26	30.00
31.00	03100	64	148	223	1	0	31.00
43.00	04300	0	108	163	0	0	43.00
44.00	04400	3,284	170	256	0	0	44.00
46.00	04600	30,189	1,562	2,354	97	2	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	1,052	1,585	918	112	50.00
51.00	05100	0	205	309	38	0	51.00
52.00	05200	0	370	557	0	0	52.00
53.00	05300	0	242	0	0	329	53.00
54.00	05400	0	1,205	0	30	59	54.00
56.00	05600	0	229	0	3	2	56.00
60.00	06000	0	974	0	92	1	60.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	383	577	4	0	65.00
66.00	06600	0	884	0	6	2	66.00
67.00	06700	0	91	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	2	0	69.00
71.00	07100	0	0	0	2,082	0	71.00
72.00	07200	0	0	0	5,922	0	72.00
73.00	07300	0	0	0	0	22,099	73.00
73.01	07301	0	74	112	2	0	73.01
73.02	07302	0	73	110	6	2	73.02
73.03	07303	0	62	93	0	0	73.03
73.04	03950	0	0	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	10	333	88.00
88.01	08801	0	0	0	4	79	88.01
88.02	08802	0	0	0	16	215	88.02
88.03	08803	0	0	0	5	88	88.03
88.04	08804	0	0	0	3	54	88.04
88.05	08805	0	0	0	0	89	88.05
90.00	09000	0	245	370	24	19	90.00
90.01	09001	0	0	0	1	0	90.01
90.02	09002	0	633	0	0	344	90.02
91.00	09100	0	603	909	121	29	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	2,257	0	22	134	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		43,037	14,061	10,311	9,696	24,018	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.01	19201	0	0	0	2	0	192.01
192.02	19202	0	0	0	0	0	192.02
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	26	0	194.01
194.02	07952	0	0	0	6	6	194.02
194.03	07953	0	0	0	1	0	194.03
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		43,037	14,061	10,311	9,731	24,024	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/26/2013 6:35 pm			
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS				4.00	
5.01	00510	PATIENT ACCOUNTING & REGIST				5.01	
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02	
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	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	18,820			16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,458	310,750	0	310,750	30.00
31.00	03100	INTENSIVE CARE UNIT	689	16,985	0	16,985	31.00
43.00	04300	NURSERY	0	6,641	0	6,641	43.00
44.00	04400	SKILLED NURSING FACILITY	0	22,360	0	22,360	44.00
46.00	04600	OTHER LONG TERM CARE	0	236,477	0	236,477	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,289	257,233	0	257,233	50.00
51.00	05100	RECOVERY ROOM	0	20,896	0	20,896	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,882	0	22,882	52.00
53.00	05300	ANESTHESIOLOGY	0	17,870	0	17,870	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,519	242,840	0	242,840	54.00
56.00	05600	RADIOISOTOPE	0	11,168	0	11,168	56.00
60.00	06000	LABORATORY	0	61,144	0	61,144	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,200	0	3,200	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	173	19,514	0	19,514	65.00
66.00	06600	PHYSICAL THERAPY	0	199,197	0	199,197	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,712	0	4,712	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,586	0	3,586	68.00
69.00	06900	ELECTROCARDIOLOGY	0	41	0	41	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,749	0	8,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	25,707	0	25,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,527	0	31,527	73.00
73.01	07301	CARDIAC REHAB	0	21,240	0	21,240	73.01
73.02	07302	WOUND CARE	0	11,287	0	11,287	73.02
73.03	07303	SLEEP LAB	0	2,043	0	2,043	73.03
73.04	03950	DIETARY EDUCATION	0	173	0	173	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - PAXTON CLINIC	0	94,278	0	94,278	88.00
88.01	08801	RHC II - ONARGA CLINIC	0	8,329	0	8,329	88.01
88.02	08802	RHC III - FORREST CLINIC	0	33,749	0	33,749	88.02
88.03	08803	RHC IV - HOOPESTON	0	22,751	0	22,751	88.03
88.04	08804	RHC V - FARMER CITY	0	16,569	0	16,569	88.04
88.05	08805	RHC VI - GIBSON CITY	0	6,406	0	6,406	88.05
90.00	09000	CLINIC	0	38,873	0	38,873	90.00
90.01	09001	GERI PSYCH CLINIC	0	12,486	0	12,486	90.01
90.02	09002	ORTHO CLINIC	0	6,721	0	6,721	90.02
91.00	09100	EMERGENCY	692	150,754	0	150,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	49,664	0	49,664	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,820	1,998,802	0	1,998,802	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,615	0	4,615	190.00
192.01	19201	GAH - MSO	0	3,087	0	3,087	192.01
192.02	19202	GAH FOUNDATION	0	943	0	943	192.02
194.00	07950	HOSPITAL ASSOC SVCS	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	2,689	0	2,689	194.01
194.02	07952	PHYSICIAN CLINICS	0	6,905	0	6,905	194.02
194.03	07953	WELLNESS CENTER	0	502	0	502	194.03
194.06	07956	LASER CLINIC	0	241	0	241	194.06
194.07	07957	PAIN CLINIC	0	145	0	145	194.07
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141317		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/26/2013 6:35 pm	
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118-201)	18,820	2,017,929	25.00	2,017,929		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141317

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

Worksheet B-1

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	PATIENT ACCOUNTING & REGIST (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	129,478					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		680,270				2.00
4.00 00400	EMPLOYEE BENEFITS	646	0	24,277,121			4.00
5.01 00510	PATIENT ACCOUNTING & REGIST	523	220	887,125	-1,626,466	35,321,042	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	14,348	194,475	2,361,542	0	6,523,646	5.02
7.00 00700	OPERATION OF PLANT	35,989	737	492,629	0	2,102,484	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,719	499	107,778	0	196,206	8.00
9.00 00900	HOUSEKEEPING	548	0	266,643	0	414,505	9.00
10.00 01000	DIETARY	2,511	5,187	189,376	0	385,044	10.00
11.00 01100	CAFETERIA	797	0	195,882	0	323,610	11.00
13.00 01300	NURSING ADMINISTRATION	298	0	453,308	0	706,691	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	704	0	0	0	24,020	14.00
15.00 01500	PHARMACY	1,325	0	421,584	0	693,523	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,031	75	340,081	0	501,151	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	13,244	73,428	1,927,936	0	2,962,575	30.00
31.00 03100	INTENSIVE CARE UNIT	970	0	231,658	0	315,144	31.00
43.00 04300	NURSERY	319	0	155,885	0	223,390	43.00
44.00 04400	SKILLED NURSING FACILITY	1,145	0	144,418	-224,310	0	44.00
46.00 04600	OTHER LONG TERM CARE	12,233	10,494	1,327,682	-2,067,321	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	6,131	135,203	1,017,341	0	2,416,644	50.00
51.00 05100	RECOVERY ROOM	1,263	308	229,499	0	337,787	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,080	0	534,657	0	766,046	52.00
53.00 05300	ANESTHESIOLOGY	98	14,595	0	0	52,676	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,227	102,949	1,100,649	0	3,233,905	54.00
56.00 05600	RADIOISOTOPE	659	0	90,339	0	235,132	56.00
60.00 06000	LABORATORY	1,877	16,940	752,206	0	1,941,315	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	154	0	0	0	131,764	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	451	6,714	396,457	0	593,094	65.00
66.00 06600	PHYSICAL THERAPY	10,649	35,506	1,140,975	0	1,764,475	66.00
67.00 06700	OCCUPATIONAL THERAPY	225	47	125,361	0	176,261	67.00
68.00 06800	SPEECH PATHOLOGY	225	0	80	0	63,942	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	4,578	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	786,379	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,333,956	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,112,173	73.00
73.01 07301	CARDIAC REHAB	1,011	5,780	85,485	0	141,428	73.01
73.02 07302	WOUND CARE	669	0	168,887	0	235,696	73.02
73.03 07303	SLEEP LAB	0	775	80,605	0	123,057	73.03
73.04 03950	DIETARY EDUCATION	0	0	0	0	20,382	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RHC - PAXTON CLINIC	0	10,936	2,273,616	-3,694,047	0	88.00
88.01 08801	RHC II -ONARGA CLINIC	0	0	306,043	-523,650	0	88.01
88.02 08802	RHC III - FORREST CLINIC	0	10,953	839,067	-1,445,421	0	88.02
88.03 08803	RHC IV - HOOPESTON	0	10,000	370,764	-631,990	0	88.03
88.04 08804	RHC V - FARMER CITY	0	3,682	351,393	-658,027	0	88.04
88.05 08805	RHC VI - GIBSON CITY	0	0	521,052	-777,064	0	88.05
90.00 09000	CLINIC	2,371	2,828	230,643	0	361,082	90.00
90.01 09001	GERI PSYCH CLINIC	0	0	134,576	0	312,143	90.01
90.02 09002	ORTHO CLINIC	0	0	294,334	0	668,290	90.02
91.00 09100	EMERGENCY	6,699	35,821	1,041,212	0	2,091,582	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	2,118	1,639,197	-2,388,868	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	129,139	680,270	23,227,965	-14,037,164	35,275,776	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	-3,389	0	190.00
192.01 19201	GAH - MSO	0	0	210,094	-380,973	0	192.01
192.02 19202	GAH FOUNDATION	0	0	12,976	-118,272	0	192.02
194.00 07950	HOSPITAL ASSOC SRVCS	0	0	0	0	33	194.00
194.01 07951	PHYSICIAN OFFICE	0	0	282,745	-325,564	0	194.01
194.02 07952	PHYSICIAN CLINICS	0	0	495,690	-850,426	0	194.02
194.03 07953	WELLNESS CENTER	0	0	40,708	-61,660	0	194.03
194.06 07956	LASER CLINIC	0	0	6,943	0	28,175	194.06
194.07 07957	PAIN CLINIC	0	0	0	0	17,058	194.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141317

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

Worksheet B-1

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	PATIENT ACCOUNTING & REGIST (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
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)	1,294,286	723,643	6,952,435		1,626,466	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.996185	1.063759	0.286378		0.046048	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			6,458		5,698	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000266		0.000161	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141317

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

Worksheet B-1

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description			Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PATIENT ACCOUNTING & REGIST						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-6,824,049	44,274,441				5.02
7.00	00700	OPERATION OF PLANT	0	2,199,299	112,437			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	205,241	1,719	283,791		8.00
9.00	00900	HOUSEKEEPING	0	433,592	548	22,138	75,705	9.00
10.00	01000	DIETARY	0	402,775	2,511	2,531	2,511	10.00
11.00	01100	CAFETERIA	0	338,512	797	5,403	797	11.00
13.00	01300	NURSING ADMINISTRATION	0	739,233	298	0	298	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,126	704	0	704	14.00
15.00	01500	PHARMACY	0	725,458	1,325	0	1,325	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	524,228	1,031	0	1,031	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,098,996	13,244	56,933	13,244	30.00
31.00	03100	INTENSIVE CARE UNIT	0	329,656	970	0	970	31.00
43.00	04300	NURSERY	0	233,677	319	1,325	319	43.00
44.00	04400	SKILLED NURSING FACILITY	0	224,310	1,145	15,023	1,145	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,067,321	12,233	98,895	12,233	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,527,926	6,131	30,731	6,131	50.00
51.00	05100	RECOVERY ROOM	0	353,341	1,263	0	1,263	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	801,321	1,080	7,914	1,080	52.00
53.00	05300	ANESTHESIOLOGY	0	55,102	98	0	98	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,382,820	7,227	11,357	7,227	54.00
56.00	05600	RADIOISOTOPE	0	245,959	659	0	659	56.00
60.00	06000	LABORATORY	0	2,030,709	1,877	0	1,877	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	137,831	154	0	154	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	620,405	451	0	451	65.00
66.00	06600	PHYSICAL THERAPY	0	1,845,726	10,649	13,141	10,649	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	184,377	225	0	225	67.00
68.00	06800	SPEECH PATHOLOGY	0	66,886	225	0	225	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,789	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	822,590	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,441,430	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,163,386	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	147,940	1,011	0	1,011	73.01
73.02	07302	WOUND CARE	0	246,549	669	0	669	73.02
73.03	07303	SLEEP LAB	0	128,724	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	21,321	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - PAXTON CLINIC	0	3,694,047	15,543	0	0	88.00
88.01	08801	RHC II - ONARGA CLINIC	0	523,650	1,189	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,445,421	3,016	0	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	631,990	2,049	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	658,027	2,160	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	777,064	0	0	0	88.05
90.00	09000	CLINIC	0	377,709	2,371	0	2,371	90.00
90.01	09001	GERI PSYCH CLINIC	0	326,517	2,912	0	0	90.01
90.02	09002	ORTHO CLINIC	0	699,063	0	0	0	90.02
91.00	09100	EMERGENCY	0	2,187,895	6,699	18,400	6,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,388,868	7,596	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,824,049	42,486,807	112,098	283,791	75,366	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,389	339	0	339	190.00
192.01	19201	GAH - MSO	0	380,973	0	0	0	192.01
192.02	19202	GAH FOUNDATION	0	118,272	0	0	0	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	35	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	325,564	0	0	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	850,426	0	0	0	194.02
194.03	07953	WELLNESS CENTER	0	61,660	0	0	0	194.03
194.06	07956	LASER CLINIC	0	29,472	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	17,843	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141317

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

Worksheet B-1

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		Reconciliation	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPING	
			ADMINISTRATIVE AND GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF LAUNDRY)	(SQUARE FEET)	
		5A.02	5.02	7.00	8.00	9.00	
202.00	Cost to be allocated (per Wkst. B, Part I)		6,824,049	2,538,279	275,682	534,298	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0.154131	22.575122	0.971426	7.057632	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		351,989	378,493	25,194	12,873	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.007950	3.366267	0.088777	0.170042	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141317

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

Worksheet B-1

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	50,641					11.00
13.00	01300	0	28,556	289,046			13.00
14.00	01400	0	0	0	3,835,780		14.00
15.00	01500	0	190	0	3,546	1,209,123	15.00
16.00	01600	0	902	0	1,849	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,179	3,630	75,498	107,695	1,329	30.00
31.00	03100	75	300	6,250	367	0	31.00
43.00	04300	0	219	4,556	0	0	43.00
44.00	04400	3,864	345	7,178	0	0	44.00
46.00	04600	35,523	3,172	65,986	38,168	92	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,136	44,436	361,841	5,658	50.00
51.00	05100	0	417	8,667	15,151	0	51.00
52.00	05200	0	751	15,625	0	0	52.00
53.00	05300	0	491	0	0	16,556	53.00
54.00	05400	0	2,448	0	11,993	2,947	54.00
56.00	05600	0	465	0	1,077	110	56.00
60.00	06000	0	1,978	0	36,134	58	60.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	778	16,187	1,407	0	65.00
66.00	06600	0	1,796	0	2,408	119	66.00
67.00	06700	0	185	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	717	0	69.00
71.00	07100	0	0	0	820,834	0	71.00
72.00	07200	0	0	0	2,333,956	0	72.00
73.00	07300	0	0	0	0	1,112,173	73.00
73.01	07301	0	151	3,142	814	0	73.01
73.02	07302	0	148	3,077	2,519	79	73.02
73.03	07303	0	125	2,598	165	0	73.03
73.04	03950	0	0	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	3,874	16,769	88.00
88.01	08801	0	0	0	1,483	3,983	88.01
88.02	08802	0	0	0	6,136	10,836	88.02
88.03	08803	0	0	0	2,078	4,426	88.03
88.04	08804	0	0	0	1,237	2,714	88.04
88.05	08805	0	0	0	0	4,482	88.05
90.00	09000	0	498	10,358	9,638	975	90.00
90.01	09001	0	0	0	355	0	90.01
90.02	09002	0	1,286	0	0	17,293	90.02
91.00	09100	0	1,225	25,488	47,509	1,476	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	4,583	0	8,850	6,746	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		50,641	28,556	289,046	3,821,801	1,208,821	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.01	19201	0	0	0	852	0	192.01
192.02	19202	0	0	0	0	0	192.02
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	10,324	0	194.01
194.02	07952	0	0	0	2,310	302	194.02
194.03	07953	0	0	0	485	0	194.03
194.06	07956	0	0	0	8	0	194.06
194.07	07957	0	0	0	0	0	194.07
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141317

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

Worksheet B-1

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	541,722	419,553	866,953	49,861	879,375	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.697301	14.692289	2.999360	0.012999	0.727283	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	43,037	14,061	10,311	9,731	24,024	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.849845	0.492401	0.035673	0.002537	0.019869	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141317

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

Worksheet B-1
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.01	00510 PATIENT ACCOUNTING & REGIST		5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL		5.02
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
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	27,180	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	12,215	30.00
31.00	03100 INTENSIVE CARE UNIT	995	31.00
43.00	04300 NURSERY	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	4,750	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,970	54.00
56.00	05600 RADIOISOTOPE	0	56.00
60.00	06000 LABORATORY	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	250	65.00
66.00	06600 PHYSICAL THERAPY	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	73.00
73.01	07301 CARDIAC REHAB	0	73.01
73.02	07302 WOUND CARE	0	73.02
73.03	07303 SLEEP LAB	0	73.03
73.04	03950 DIETARY EDUCATION	0	73.04
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RHC - PAXTON CLINIC	0	88.00
88.01	08801 RHC II - ONARGA CLINIC	0	88.01
88.02	08802 RHC III - FORREST CLINIC	0	88.02
88.03	08803 RHC IV - HOOPESTON	0	88.03
88.04	08804 RHC V - FARMER CITY	0	88.04
88.05	08805 RHC VI - GIBSON CITY	0	88.05
90.00	09000 CLINIC	0	90.00
90.01	09001 GERI PSYCH CLINIC	0	90.01
90.02	09002 ORTHO CLINIC	0	90.02
91.00	09100 EMERGENCY	1,000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,180	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.01	19201 GAH - MSO	0	192.01
192.02	19202 GAH FOUNDATION	0	192.02
194.00	07950 HOSPITAL ASSOC SRVCS	0	194.00
194.01	07951 PHYSICIAN OFFICE	0	194.01
194.02	07952 PHYSICIAN CLINICS	0	194.02
194.03	07953 WELLNESS CENTER	0	194.03
194.06	07956 LASER CLINIC	0	194.06
194.07	07957 PAIN CLINIC	0	194.07
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141317

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

Worksheet B-1

Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	648,855	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	23.872517	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	18,820	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.692421	205.00

Provider CCN: 141317

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

Worksheet B-2

Date/Time Prepared:
 2/26/2013 6:35 pm

	Description	Worksheet		Amount	
		Part	Line No.		
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4.00
5.00	IV THERAPY RECLASS		1 64.00	63,698	5.00
6.00	IV THERAPY RECLASS		1 30.00	-63,698	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/26/2013 6:35 pm	
			Title XVIII	Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		4,654,044	0	4,654,044	30.00
31.00	03100 INTENSIVE CARE UNIT		456,924	0	456,924	31.00
43.00	04300 NURSERY		297,316	0	297,316	43.00
44.00	04400 SKILLED NURSING FACILITY		375,339	0	375,339	44.00
46.00	04600 OTHER LONG TERM CARE		3,469,609	0	3,469,609	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		3,415,965	0	3,415,965	50.00
51.00	05100 RECOVERY ROOM		477,547	0	477,547	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,022,419	0	1,022,419	52.00
53.00	05300 ANESTHESIOLOGY		85,754	0	85,754	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,357,935	0	4,357,935	54.00
56.00	05600 RADIOISOTOPE		310,323	0	310,323	56.00
60.00	06000 LABORATORY		2,428,898	0	2,428,898	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		163,639	0	163,639	63.00
64.00	06400 INTRAVENOUS THERAPY		63,698	0	63,698	64.00
65.00	06500 RESPIRATORY THERAPY	0	795,361	0	795,361	65.00
66.00	06600 PHYSICAL THERAPY	0	2,485,040	0	2,485,040	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	222,180	0	222,180	67.00
68.00	06800 SPEECH PATHOLOGY	0	83,862	0	83,862	68.00
69.00	06900 ELECTROCARDIOLOGY		5,536	0	5,536	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		960,047	0	960,047	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		2,848,069	0	2,848,069	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,151,564	0	2,151,564	73.00
73.01	07301 CARDIAC REHAB		212,354	0	212,354	73.01
73.02	07302 WOUND CARE		315,868	0	315,868	73.02
73.03	07303 SLEEP LAB		158,195	0	158,195	73.03
73.04	03950 DIETARY EDUCATION		24,607	0	24,607	73.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - PAXTON CLINIC		4,626,533	0	4,626,533	88.00
88.01	08801 RHC II -ONARGA CLINIC		634,119	0	634,119	88.01
88.02	08802 RHC III - FORREST CLINIC		1,744,253	0	1,744,253	88.02
88.03	08803 RHC IV - HOOPESTON		778,901	0	778,901	88.03
88.04	08804 RHC V - FARMER CITY		810,201	0	810,201	88.04
88.05	08805 RHC VI - GIBSON CITY		900,094	0	900,094	88.05
90.00	09000 CLINIC		545,404	0	545,404	90.00
90.01	09001 GERI PSYCH CLINIC		442,587	0	442,587	90.01
90.02	09002 ORTHO CLINIC		838,281	0	838,281	90.02
91.00	09100 EMERGENCY		2,861,511	0	2,861,511	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		372,101	0	372,101	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		3,000,902	0	3,000,902	95.00
200.00	Subtotal (see instructions)		49,396,980	0	49,396,980	200.00
201.00	Less Observation Beds		372,101	0	372,101	201.00
202.00	Total (see instructions)		49,024,879	0	49,024,879	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 141317		Period: From 10/01/2011 To 09/30/2012		Worksheet C Part I Date/Time Prepared: 2/26/2013 6:35 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	4,445,982		4,445,982			30.00
31.00	03100	INTENSIVE CARE UNIT	102,320		102,320			31.00
43.00	04300	NURSERY	362,984		362,984			43.00
44.00	04400	SKILLED NURSING FACILITY	265,333		265,333			44.00
46.00	04600	OTHER LONG TERM CARE	2,089,924		2,089,924			46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,918,417	8,422,266	12,340,683	0.276805	0.000000	50.00
51.00	05100	RECOVERY ROOM	441,094	1,693,271	2,134,365	0.223742	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,026,014	218,956	1,244,970	0.821240	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	25,263	33,132	58,395	1.468516	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,133,236	17,405,480	18,538,716	0.235072	0.000000	54.00
56.00	05600	RADIOISOTOPE	22,711	1,122,499	1,145,210	0.270975	0.000000	56.00
60.00	06000	LABORATORY	1,244,846	10,805,141	12,049,987	0.201569	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	85,327	27,817	113,144	1.446290	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	15,834	645,588	661,422	0.096305	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,722,831	856,574	3,579,405	0.222205	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,003,720	4,251,851	5,255,571	0.472839	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,351	138,835	575,186	0.386275	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	34,969	66,728	101,697	0.824626	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	78,569	657,973	736,542	0.007516	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,791,079	2,633,392	4,424,471	0.216986	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,067,386	676,773	6,744,159	0.422302	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,540,023	7,149,007	11,689,030	0.184067	0.000000	73.00
73.01	07301	CARDIAC REHAB	0	148,337	148,337	1.431565	0.000000	73.01
73.02	07302	WOUND CARE	3,721	155,855	159,576	1.979420	0.000000	73.02
73.03	07303	SLEEP LAB	0	491,889	491,889	0.321607	0.000000	73.03
73.04	03950	DIETARY EDUCATION	7,607	12,775	20,382	1.207291	0.000000	73.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - PAXTON CLINIC	0	3,580,477	3,580,477			88.00
88.01	08801	RHC II -ONARGA CLINIC	0	464,475	464,475			88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,377,505	1,377,505			88.02
88.03	08803	RHC IV - HOOPESTON	0	332,625	332,625			88.03
88.04	08804	RHC V - FARMER CITY	0	430,452	430,452			88.04
88.05	08805	RHC VI - GIBSON CITY	0	784,192	784,192			88.05
90.00	09000	CLINIC	4,620	501,026	505,646	1.078628	0.000000	90.00
90.01	09001	GERI PSYCH CLINIC	0	288,570	288,570	1.533725	0.000000	90.01
90.02	09002	ORTHO CLINIC	0	875,131	875,131	0.957892	0.000000	90.02
91.00	09100	EMERGENCY	3,728	4,941,738	4,945,466	0.578613	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,831	361,615	369,446	1.007186	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	3,707,306	3,707,306	0.809456	0.000000	95.00
200.00		Subtotal (see instructions)	31,881,720	75,259,251	107,140,971			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,881,720	75,259,251	107,140,971			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/26/2013 6:35 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XVIII	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301 CARDIAC REHAB	0.000000		73.01
73.02	07302 WOUND CARE	0.000000		73.02
73.03	07303 SLEEP LAB	0.000000		73.03
73.04	03950 DIETARY EDUCATION	0.000000		73.04
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC - PAXTON CLINIC			88.00
88.01	08801 RHC II -ONARGA CLINIC			88.01
88.02	08802 RHC III - FORREST CLINIC			88.02
88.03	08803 RHC IV - HOOPESTON			88.03
88.04	08804 RHC V - FARMER CITY			88.04
88.05	08805 RHC VI - GIBSON CITY			88.05
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 GERI PSYCH CLINIC	0.000000		90.01
90.02	09002 ORTHO CLINIC	0.000000		90.02
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/26/2013 6:35 pm	
			Title XIX	Hospital	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		4,654,044	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		456,924	0	0	31.00
43.00	04300 NURSERY		297,316	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		375,339	0	0	44.00
46.00	04600 OTHER LONG TERM CARE		3,469,609	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		3,415,965	0	0	50.00
51.00	05100 RECOVERY ROOM		477,547	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,022,419	0	0	52.00
53.00	05300 ANESTHESIOLOGY		85,754	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,357,935	0	0	54.00
56.00	05600 RADIOISOTOPE		310,323	0	0	56.00
60.00	06000 LABORATORY		2,428,898	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		163,639	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY		63,698	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	795,361	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,485,040	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	222,180	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	83,862	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		5,536	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		960,047	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		2,848,069	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,151,564	0	0	73.00
73.01	07301 CARDIAC REHAB		212,354	0	0	73.01
73.02	07302 WOUND CARE		315,868	0	0	73.02
73.03	07303 SLEEP LAB		158,195	0	0	73.03
73.04	03950 DIETARY EDUCATION		24,607	0	0	73.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - PAXTON CLINIC		4,626,533	0	0	88.00
88.01	08801 RHC II -ONARGA CLINIC		634,119	0	0	88.01
88.02	08802 RHC III - FORREST CLINIC		1,744,253	0	0	88.02
88.03	08803 RHC IV - HOOPESTON		778,901	0	0	88.03
88.04	08804 RHC V - FARMER CITY		810,201	0	0	88.04
88.05	08805 RHC VI - GIBSON CITY		900,094	0	0	88.05
90.00	09000 CLINIC		545,404	0	0	90.00
90.01	09001 GERI PSYCH CLINIC		442,587	0	0	90.01
90.02	09002 ORTHO CLINIC		838,281	0	0	90.02
91.00	09100 EMERGENCY		2,861,511	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		372,101	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		3,000,902	0	0	95.00
200.00	Subtotal (see instructions)		49,396,980	0	0	200.00
201.00	Less Observation Beds		372,101	0	0	201.00
202.00	Total (see instructions)		49,024,879	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141317

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

Worksheet C
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

		Title XIX			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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,445,982		4,445,982		30.00
31.00	03100	INTENSIVE CARE UNIT	102,320		102,320		31.00
43.00	04300	NURSERY	362,984		362,984		43.00
44.00	04400	SKILLED NURSING FACILITY	265,333		265,333		44.00
46.00	04600	OTHER LONG TERM CARE	2,089,924		2,089,924		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,918,417	8,422,266	12,340,683	0.276805	50.00
51.00	05100	RECOVERY ROOM	441,094	1,693,271	2,134,365	0.223742	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,026,014	218,956	1,244,970	0.821240	52.00
53.00	05300	ANESTHESIOLOGY	25,263	33,132	58,395	1.468516	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,133,236	17,405,480	18,538,716	0.235072	54.00
56.00	05600	RADIOISOTOPE	22,711	1,122,499	1,145,210	0.270975	56.00
60.00	06000	LABORATORY	1,244,846	10,805,141	12,049,987	0.201569	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	85,327	27,817	113,144	1.446290	63.00
64.00	06400	INTRAVENOUS THERAPY	15,834	645,588	661,422	0.096305	64.00
65.00	06500	RESPIRATORY THERAPY	2,722,831	856,574	3,579,405	0.222205	65.00
66.00	06600	PHYSICAL THERAPY	1,003,720	4,251,851	5,255,571	0.472839	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,351	138,835	575,186	0.386275	67.00
68.00	06800	SPEECH PATHOLOGY	34,969	66,728	101,697	0.824626	68.00
69.00	06900	ELECTROCARDIOLOGY	78,569	657,973	736,542	0.007516	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,791,079	2,633,392	4,424,471	0.216986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,067,386	676,773	6,744,159	0.422302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,540,023	7,149,007	11,689,030	0.184067	73.00
73.01	07301	CARDIAC REHAB	0	148,337	148,337	1.431565	73.01
73.02	07302	WOUND CARE	3,721	155,855	159,576	1.979420	73.02
73.03	07303	SLEEP LAB	0	491,889	491,889	0.321607	73.03
73.04	03950	DIETARY EDUCATION	7,607	12,775	20,382	1.207291	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - PAXTON CLINIC	0	3,580,477	3,580,477	1.292155	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	464,475	464,475	1.365238	88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,377,505	1,377,505	1.266241	88.02
88.03	08803	RHC IV - HOOPESTON	0	332,625	332,625	2.341679	88.03
88.04	08804	RHC V - FARMER CITY	0	430,452	430,452	1.882210	88.04
88.05	08805	RHC VI - GIBSON CITY	0	784,192	784,192	1.147798	88.05
90.00	09000	CLINIC	4,620	501,026	505,646	1.078628	90.00
90.01	09001	GERI PSYCH CLINIC	0	288,570	288,570	1.533725	90.01
90.02	09002	ORTHO CLINIC	0	875,131	875,131	0.957892	90.02
91.00	09100	EMERGENCY	3,728	4,941,738	4,945,466	0.578613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,831	361,615	369,446	1.007186	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	3,707,306	3,707,306	0.809456	95.00
200.00		Subtotal (see instructions)	31,881,720	75,259,251	107,140,971		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	31,881,720	75,259,251	107,140,971		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141317

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

Worksheet C
Part I
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
46.00	04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301 CARDIAC REHAB	0.000000			73.01
73.02	07302 WOUND CARE	0.000000			73.02
73.03	07303 SLEEP LAB	0.000000			73.03
73.04	03950 DIETARY EDUCATION	0.000000			73.04
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - PAXTON CLINIC	0.000000			88.00
88.01	08801 RHC II -ONARGA CLINIC	0.000000			88.01
88.02	08802 RHC III - FORREST CLINIC	0.000000			88.02
88.03	08803 RHC IV - HOOPESTON	0.000000			88.03
88.04	08804 RHC V - FARMER CITY	0.000000			88.04
88.05	08805 RHC VI - GIBSON CITY	0.000000			88.05
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 GERI PSYCH CLINIC	0.000000			90.01
90.02	09002 ORTHO CLINIC	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
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: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/26/2013 6:35 pm
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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)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	257,233	12,340,683	0.020844	1,701,010	35,456	50.00
51.00	05100 RECOVERY ROOM	20,896	2,134,365	0.009790	202,406	1,982	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22,882	1,244,970	0.018380	0	0	52.00
53.00	05300 ANESTHESIOLOGY	17,870	58,395	0.306019	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	242,840	18,538,716	0.013099	627,996	8,226	54.00
56.00	05600 RADIOISOTOPE	11,168	1,145,210	0.009752	13,868	135	56.00
60.00	06000 LABORATORY	61,144	12,049,987	0.005074	710,011	3,603	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3,200	113,144	0.028283	56,911	1,610	63.00
64.00	06400 INTRAVENOUS THERAPY	0	661,422	0.000000	6,612	0	64.00
65.00	06500 RESPIRATORY THERAPY	19,514	3,579,405	0.005452	1,674,054	9,127	65.00
66.00	06600 PHYSICAL THERAPY	199,197	5,255,571	0.037902	179,051	6,786	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,712	575,186	0.008192	46,977	385	67.00
68.00	06800 SPEECH PATHOLOGY	3,586	101,697	0.035262	14,701	518	68.00
69.00	06900 ELECTROCARDIOLOGY	41	736,542	0.000056	54,690	3	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,749	4,424,471	0.001977	661,093	1,307	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	25,707	6,744,159	0.003812	2,946,786	11,233	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	31,527	11,689,030	0.002697	2,006,222	5,411	73.00
73.01	07301 CARDIAC REHAB	21,240	148,337	0.143187	0	0	73.01
73.02	07302 WOUND CARE	11,287	159,576	0.070731	770	54	73.02
73.03	07303 SLEEP LAB	2,043	491,889	0.004153	0	0	73.03
73.04	03950 DIETARY EDUCATION	173	20,382	0.008488	3,630	31	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - PAXTON CLINIC	94,278	3,580,477	0.026331	0	0	88.00
88.01	08801 RHC II -ONARGA CLINIC	8,329	464,475	0.017932	0	0	88.01
88.02	08802 RHC III - FORREST CLINIC	33,749	1,377,505	0.024500	0	0	88.02
88.03	08803 RHC IV - HOOPESTON	22,751	332,625	0.068398	0	0	88.03
88.04	08804 RHC V - FARMER CITY	16,569	430,452	0.038492	0	0	88.04
88.05	08805 RHC VI - GIBSON CITY	6,406	784,192	0.008169	0	0	88.05
90.00	09000 CLINIC	38,873	505,646	0.076878	0	0	90.00
90.01	09001 GERI PSYCH CLINIC	12,486	288,570	0.043269	0	0	90.01
90.02	09002 ORTHO CLINIC	6,721	875,131	0.007680	0	0	90.02
91.00	09100 EMERGENCY	150,754	4,945,466	0.030483	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	369,446	0.000000	1,883	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,355,925	96,167,122		10,908,671	85,867	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	0	0	0	73.01
73.02	07302	WOUND CARE	0	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - PAXTON CLINIC	0	0	0	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0	0	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	0	0	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 6:35 pm
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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	12,340,683	0.000000	0.000000	1,701,010	50.00
51.00	05100 RECOVERY ROOM	0	2,134,365	0.000000	0.000000	202,406	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,244,970	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	58,395	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	18,538,716	0.000000	0.000000	627,996	54.00
56.00	05600 RADIOISOTOPE	0	1,145,210	0.000000	0.000000	13,868	56.00
60.00	06000 LABORATORY	0	12,049,987	0.000000	0.000000	710,011	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	113,144	0.000000	0.000000	56,911	63.00
64.00	06400 INTRAVENOUS THERAPY	0	661,422	0.000000	0.000000	6,612	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,579,405	0.000000	0.000000	1,674,054	65.00
66.00	06600 PHYSICAL THERAPY	0	5,255,571	0.000000	0.000000	179,051	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	575,186	0.000000	0.000000	46,977	67.00
68.00	06800 SPEECH PATHOLOGY	0	101,697	0.000000	0.000000	14,701	68.00
69.00	06900 ELECTROCARDIOLOGY	0	736,542	0.000000	0.000000	54,690	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,424,471	0.000000	0.000000	661,093	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6,744,159	0.000000	0.000000	2,946,786	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,689,030	0.000000	0.000000	2,006,222	73.00
73.01	07301 CARDIAC REHAB	0	148,337	0.000000	0.000000	0	73.01
73.02	07302 WOUND CARE	0	159,576	0.000000	0.000000	770	73.02
73.03	07303 SLEEP LAB	0	491,889	0.000000	0.000000	0	73.03
73.04	03950 DIETARY EDUCATION	0	20,382	0.000000	0.000000	3,630	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - PAXTON CLINIC	0	3,580,477	0.000000	0.000000	0	88.00
88.01	08801 RHC II -ONARGA CLINIC	0	464,475	0.000000	0.000000	0	88.01
88.02	08802 RHC III - FORREST CLINIC	0	1,377,505	0.000000	0.000000	0	88.02
88.03	08803 RHC IV - HOOPESTON	0	332,625	0.000000	0.000000	0	88.03
88.04	08804 RHC V - FARMER CITY	0	430,452	0.000000	0.000000	0	88.04
88.05	08805 RHC VI - GIBSON CITY	0	784,192	0.000000	0.000000	0	88.05
90.00	09000 CLINIC	0	505,646	0.000000	0.000000	0	90.00
90.01	09001 GERI PSYCH CLINIC	0	288,570	0.000000	0.000000	0	90.01
90.02	09002 ORTHO CLINIC	0	875,131	0.000000	0.000000	0	90.02
91.00	09100 EMERGENCY	0	4,945,466	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	369,446	0.000000	0.000000	1,883	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	96,167,122			10,908,671	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2013 6:35 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	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301 CARDIAC REHAB	0	0	0	0	0	73.01
73.02	07302 WOUND CARE	0	0	0	0	0	73.02
73.03	07303 SLEEP LAB	0	0	0	0	0	73.03
73.04	03950 DIETARY EDUCATION	0	0	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - PAXTON CLINIC	0	0	0	0	0	88.00
88.01	08801 RHC II -ONARGA CLINIC	0	0	0	0	0	88.01
88.02	08802 RHC III - FORREST CLINIC	0	0	0	0	0	88.02
88.03	08803 RHC IV - HOOPESTON	0	0	0	0	0	88.03
88.04	08804 RHC V - FARMER CITY	0	0	0	0	0	88.04
88.05	08805 RHC VI - GIBSON CITY	0	0	0	0	0	88.05
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002 ORTHO CLINIC	0	0	0	0	0	90.02
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2013 6:35 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	CARDIAC REHAB	0	0		73.01
73.02	07302	WOUND CARE	0	0		73.02
73.03	07303	SLEEP LAB	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0		73.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0		88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0		88.01
88.02	08802	RHC III - FORREST CLINIC	0	0		88.02
88.03	08803	RHC IV - HOOPESTON	0	0		88.03
88.04	08804	RHC V - FARMER CITY	0	0		88.04
88.05	08805	RHC VI - GIBSON CITY	0	0		88.05
90.00	09000	CLINIC	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0		90.01
90.02	09002	ORTHO CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Cost		
			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	0.276805	0	2,786,270	0	50.00
51.00	05100	RECOVERY ROOM	0.223742	0	577,319	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.821240	0	1,000	0	52.00
53.00	05300	ANESTHESIOLOGY	1.468516	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235072	0	6,099,120	0	54.00
56.00	05600	RADIOISOTOPE	0.270975	0	473,810	0	56.00
60.00	06000	LABORATORY	0.201569	0	5,223,867	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.446290	0	18,902	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.096305	0	229,975	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.222205	0	340,655	0	65.00
66.00	06600	PHYSICAL THERAPY	0.472839	0	1,405,098	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386275	0	64,829	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.824626	0	24,752	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007516	0	274,564	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216986	0	628,081	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.422302	0	216,300	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184067	0	4,069,777	5,277	73.00
73.01	07301	CARDIAC REHAB	1.431565	0	74,288	0	73.01
73.02	07302	WOUND CARE	1.979420	0	73,490	0	73.02
73.03	07303	SLEEP LAB	0.321607	0	144,956	0	73.03
73.04	03950	DIETARY EDUCATION	1.207291	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - PAXTON CLINIC	0.000000				88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000				88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000				88.02
88.03	08803	RHC IV - HOOPESTON	0.000000				88.03
88.04	08804	RHC V - FARMER CITY	0.000000				88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000				88.05
90.00	09000	CLINIC	1.078628	0	259,409	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.533725	0	283,085	0	90.01
90.02	09002	ORTHO CLINIC	0.957892	0	56,995	0	90.02
91.00	09100	EMERGENCY	0.578613	0	1,409,482	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.007186	0	137,735	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.809456		0		95.00
200.00		Subtotal (see instructions)		0	24,873,759	5,277	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	24,873,759	5,277	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	771,253	0	50.00
51.00	05100	RECOVERY ROOM	0	129,171	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	821	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,433,732	0	54.00
56.00	05600	RADIOISOTOPE	0	128,391	0	56.00
60.00	06000	LABORATORY	0	1,052,970	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	27,338	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	22,148	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	75,695	0	65.00
66.00	06600	PHYSICAL THERAPY	0	664,385	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,042	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	20,411	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,064	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	136,285	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	91,344	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	749,112	971	73.00
73.01	07301	CARDIAC REHAB	0	106,348	0	73.01
73.02	07302	WOUND CARE	0	145,468	0	73.02
73.03	07303	SLEEP LAB	0	46,619	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0	88.05
90.00	09000	CLINIC	0	279,806	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	434,175	0	90.01
90.02	09002	ORTHO CLINIC	0	54,595	0	90.02
91.00	09100	EMERGENCY	0	815,545	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	138,725	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	7,351,443	971	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	7,351,443	971	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/26/2013 6:35 pm
		Component CCN: 14Z317		
Title XVIII			Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			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	0.276805	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.223742	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.821240	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	1.468516	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.235072	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.270975	0	0	0	56.00
60.00	06000 LABORATORY	0.201569	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1.446290	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.096305	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.222205	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.472839	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.386275	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.824626	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.007516	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216986	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.422302	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.184067	0	0	0	73.00
73.01	07301 CARDIAC REHAB	1.431565	0	0	0	73.01
73.02	07302 WOUND CARE	1.979420	0	0	0	73.02
73.03	07303 SLEEP LAB	0.321607	0	0	0	73.03
73.04	03950 DIETARY EDUCATION	1.207291	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - PAXTON CLINIC	0.000000				88.00
88.01	08801 RHC II -ONARGA CLINIC	0.000000				88.01
88.02	08802 RHC III - FORREST CLINIC	0.000000				88.02
88.03	08803 RHC IV - HOOPESTON	0.000000				88.03
88.04	08804 RHC V - FARMER CITY	0.000000				88.04
88.05	08805 RHC VI - GIBSON CITY	0.000000				88.05
90.00	09000 CLINIC	1.078628	0	0	0	90.00
90.01	09001 GERI PSYCH CLINIC	1.533725	0	0	0	90.01
90.02	09002 ORTHO CLINIC	0.957892	0	0	0	90.02
91.00	09100 EMERGENCY	0.578613	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.007186	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.809456		0		95.00
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: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/26/2013 6:35 pm
		Component CCN: 14Z317		
Title XVIII			Swing Beds - SNF	Cost

Cost Center Description	Costs				Cost	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	0	73.01
73.02	07302	WOUND CARE	0	0	0	73.02
73.03	07303	SLEEP LAB	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 6:35 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		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
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301 CARDIAC REHAB	0	0	0	0	0	73.01
73.02	07302 WOUND CARE	0	0	0	0	0	73.02
73.03	07303 SLEEP LAB	0	0	0	0	0	73.03
73.04	03950 DIETARY EDUCATION	0	0	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - PAXTON CLINIC	0	0	0	0	0	88.00
88.01	08801 RHC II -ONARGA CLINIC	0	0	0	0	0	88.01
88.02	08802 RHC III - FORREST CLINIC	0	0	0	0	0	88.02
88.03	08803 RHC IV - HOOPESTON	0	0	0	0	0	88.03
88.04	08804 RHC V - FARMER CITY	0	0	0	0	0	88.04
88.05	08805 RHC VI - GIBSON CITY	0	0	0	0	0	88.05
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002 ORTHO CLINIC	0	0	0	0	0	90.02
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Skilled Nursing Facility PPS

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	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	12,340,683	0.000000	0.000000	0 50.00
51.00	05100	RECOVERY ROOM	0	2,134,365	0.000000	0.000000	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,244,970	0.000000	0.000000	0 52.00
53.00	05300	ANESTHESIOLOGY	0	58,395	0.000000	0.000000	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,538,716	0.000000	0.000000	8,444 54.00
56.00	05600	RADIOISOTOPE	0	1,145,210	0.000000	0.000000	0 56.00
60.00	06000	LABORATORY	0	12,049,987	0.000000	0.000000	20,501 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	113,144	0.000000	0.000000	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	661,422	0.000000	0.000000	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	3,579,405	0.000000	0.000000	0 65.00
66.00	06600	PHYSICAL THERAPY	0	5,255,571	0.000000	0.000000	287,725 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	575,186	0.000000	0.000000	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	101,697	0.000000	0.000000	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	736,542	0.000000	0.000000	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,424,471	0.000000	0.000000	5,395 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,744,159	0.000000	0.000000	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,689,030	0.000000	0.000000	46,004 73.00
73.01	07301	CARDIAC REHAB	0	148,337	0.000000	0.000000	0 73.01
73.02	07302	WOUND CARE	0	159,576	0.000000	0.000000	0 73.02
73.03	07303	SLEEP LAB	0	491,889	0.000000	0.000000	0 73.03
73.04	03950	DIETARY EDUCATION	0	20,382	0.000000	0.000000	0 73.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - PAXTON CLINIC	0	3,580,477	0.000000	0.000000	0 88.00
88.01	08801	RHC II -ONARGA CLINIC	0	464,475	0.000000	0.000000	0 88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,377,505	0.000000	0.000000	0 88.02
88.03	08803	RHC IV - HOOPESTON	0	332,625	0.000000	0.000000	0 88.03
88.04	08804	RHC V - FARMER CITY	0	430,452	0.000000	0.000000	0 88.04
88.05	08805	RHC VI - GIBSON CITY	0	784,192	0.000000	0.000000	0 88.05
90.00	09000	CLINIC	0	505,646	0.000000	0.000000	0 90.00
90.01	09001	GERI PSYCH CLINIC	0	288,570	0.000000	0.000000	0 90.01
90.02	09002	ORTHO CLINIC	0	875,131	0.000000	0.000000	0 90.02
91.00	09100	EMERGENCY	0	4,945,466	0.000000	0.000000	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	369,446	0.000000	0.000000	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50-199)	0	96,167,122			368,069 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 6:35 pm
	Component CCN: 145979	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	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	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 07301 CARDIAC REHAB	0	0	0	0	0	73.01
73.02 07302 WOUND CARE	0	0	0	0	0	73.02
73.03 07303 SLEEP LAB	0	0	0	0	0	73.03
73.04 03950 DIETARY EDUCATION	0	0	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RHC - PAXTON CLINIC	0	0	0	0	0	88.00
88.01 08801 RHC II -ONARGA CLINIC	0	0	0	0	0	88.01
88.02 08802 RHC III - FORREST CLINIC	0	0	0	0	0	88.02
88.03 08803 RHC IV - HOOPESTON	0	0	0	0	0	88.03
88.04 08804 RHC V - FARMER CITY	0	0	0	0	0	88.04
88.05 08805 RHC VI - GIBSON CITY	0	0	0	0	0	88.05
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02 09002 ORTHO CLINIC	0	0	0	0	0	90.02
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
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 6:35 pm
	Component CCN: 145979	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301 CARDIAC REHAB	0	0	73.01
73.02	07302 WOUND CARE	0	0	73.02
73.03	07303 SLEEP LAB	0	0	73.03
73.04	03950 DIETARY EDUCATION	0	0	73.04
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC - PAXTON CLINIC	0	0	88.00
88.01	08801 RHC II -ONARGA CLINIC	0	0	88.01
88.02	08802 RHC III - FORREST CLINIC	0	0	88.02
88.03	08803 RHC IV - HOOPESTON	0	0	88.03
88.04	08804 RHC V - FARMER CITY	0	0	88.04
88.05	08805 RHC VI - GIBSON CITY	0	0	88.05
90.00	09000 CLINIC	0	0	90.00
90.01	09001 GERI PSYCH CLINIC	0	0	90.01
90.02	09002 ORTHO CLINIC	0	0	90.02
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.276805	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.223742	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.821240	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	1.468516	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.235072	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.270975	0	0	0	56.00
60.00	06000 LABORATORY	0.201569	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1.446290	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.096305	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.222205	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.472839	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.386275	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.824626	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.007516	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216986	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.422302	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.184067	0	0	1,692	73.00
73.01	07301 CARDIAC REHAB	1.431565	0	0	0	73.01
73.02	07302 WOUND CARE	1.979420	0	0	0	73.02
73.03	07303 SLEEP LAB	0.321607	0	0	0	73.03
73.04	03950 DIETARY EDUCATION	1.207291	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - PAXTON CLINIC	0.000000				88.00
88.01	08801 RHC II -ONARGA CLINIC	0.000000				88.01
88.02	08802 RHC III - FORREST CLINIC	0.000000				88.02
88.03	08803 RHC IV - HOOPESTON	0.000000				88.03
88.04	08804 RHC V - FARMER CITY	0.000000				88.04
88.05	08805 RHC VI - GIBSON CITY	0.000000				88.05
90.00	09000 CLINIC	1.078628	0	0	0	90.00
90.01	09001 GERI PSYCH CLINIC	1.533725	0	0	0	90.01
90.02	09002 ORTHO CLINIC	0.957892	0	0	0	90.02
91.00	09100 EMERGENCY	0.578613	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.007186	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.809456		0		95.00
200.00	Subtotal (see instructions)		0	0	1,692	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	1,692	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141317	Period:	Worksheet D
	Component CCN: 145979	From 10/01/2011 To 09/30/2012	Part V Date/Time Prepared: 2/26/2013 6:35 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Costs			
	PPS Services (see inst.)	Cost	Cost	
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	56.00
60.00 06000 LABORATORY	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	311	73.00
73.01 07301 CARDIAC REHAB	0	0	0	73.01
73.02 07302 WOUND CARE	0	0	0	73.02
73.03 07303 SLEEP LAB	0	0	0	73.03
73.04 03950 DIETARY EDUCATION	0	0	0	73.04
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RHC - PAXTON CLINIC	0	0	0	88.00
88.01 08801 RHC II -ONARGA CLINIC	0	0	0	88.01
88.02 08802 RHC III - FORREST CLINIC	0	0	0	88.02
88.03 08803 RHC IV - HOOPESTON	0	0	0	88.03
88.04 08804 RHC V - FARMER CITY	0	0	0	88.04
88.05 08805 RHC VI - GIBSON CITY	0	0	0	88.05
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 GERI PSYCH CLINIC	0	0	0	90.01
90.02 09002 ORTHO CLINIC	0	0	0	90.02
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES		0		95.00
200.00 Subtotal (see instructions)	0	0	311	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	311	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 6:35 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,726 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,672 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)			2,377 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			254 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)			760 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			10 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)			30 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,237 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)			224 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)			671 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			
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			116.26 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			116.26 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,654,044 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)			1,163 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)			3,488 25.00
26.00	Total swing-bed cost (see instructions)			1,283,680 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,370,364 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			7,084,804 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			7,084,804 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.475717 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)			2,980.57 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)			3,370,364 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)			1,261.37 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,560,315 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)			1,560,315 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 6:35 pm		
Cost Center Description			Title XVIII		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	456,924	50	9,138.48	41	374,678	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)					3,145,869	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,080,862	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)					282,547	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					846,379	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,128,926	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)					295	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,261.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					372,101	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141317		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 6:35 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Skilled Nursing Facility	PPS
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)		1,288	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,288	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)		1,288	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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)		0	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)		848	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)		0	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)		0	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		375,339	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)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		375,339	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		265,333	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		265,333	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.414596	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)		206.00	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)		375,339	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141317 Component CCN: 145979		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 6:35 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					375,339	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					291.41	71.00
72.00	Program routine service cost (line 9 x line 71)					247,116	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					247,116	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					247,116	83.00
84.00	Program inpatient ancillary services (see instructions)					151,804	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					398,920	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141317 Component CCN: 145979		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 6:35 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/26/2013 6:35 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,001,610	30.00
31.00	03100	INTENSIVE CARE UNIT		77,555	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.276805	1,701,010	50.00
51.00	05100	RECOVERY ROOM	0.223742	202,406	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.821240	0	52.00
53.00	05300	ANESTHESIOLOGY	1.468516	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235072	627,996	54.00
56.00	05600	RADIOISOTOPE	0.270975	13,868	56.00
60.00	06000	LABORATORY	0.201569	710,011	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.446290	56,911	63.00
64.00	06400	INTRAVENOUS THERAPY	0.096305	6,612	64.00
65.00	06500	RESPIRATORY THERAPY	0.222205	1,674,054	65.00
66.00	06600	PHYSICAL THERAPY	0.472839	179,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386275	46,977	67.00
68.00	06800	SPEECH PATHOLOGY	0.824626	14,701	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007516	54,690	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216986	661,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.422302	2,946,786	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184067	2,006,222	73.00
73.01	07301	CARDIAC REHAB	1.431565	0	73.01
73.02	07302	WOUND CARE	1.979420	770	73.02
73.03	07303	SLEEP LAB	0.321607	0	73.03
73.04	03950	DIETARY EDUCATION	1.207291	3,630	73.04
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - PAXTON CLINIC	0.000000		88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000		88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000		88.02
88.03	08803	RHC IV - HOOPESTON	0.000000		88.03
88.04	08804	RHC V - FARMER CITY	0.000000		88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000		88.05
90.00	09000	CLINIC	1.078628	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.533725	0	90.01
90.02	09002	ORTHO CLINIC	0.957892	0	90.02
91.00	09100	EMERGENCY	0.578613	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.007186	1,883	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		10,908,671	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		10,908,671	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3	
		Component CCN: 14Z317		Date/Time Prepared: 2/26/2013 6:35 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.276805	0	50.00
51.00	05100	RECOVERY ROOM	0.223742	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.821240	0	52.00
53.00	05300	ANESTHESIOLOGY	1.468516	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235072	65,746	54.00
56.00	05600	RADIOISOTOPE	0.270975	0	56.00
60.00	06000	LABORATORY	0.201569	112,224	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.446290	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.096305	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.222205	171,511	65.00
66.00	06600	PHYSICAL THERAPY	0.472839	179,277	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386275	74,511	67.00
68.00	06800	SPEECH PATHOLOGY	0.824626	1,806	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007516	5,861	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216986	313,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.422302	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184067	645,600	73.00
73.01	07301	CARDIAC REHAB	1.431565	0	73.01
73.02	07302	WOUND CARE	1.979420	0	73.02
73.03	07303	SLEEP LAB	0.321607	0	73.03
73.04	03950	DIETARY EDUCATION	1.207291	0	73.04
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - PAXTON CLINIC	0.000000		88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000		88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000		88.02
88.03	08803	RHC IV - HOOPESTON	0.000000		88.03
88.04	08804	RHC V - FARMER CITY	0.000000		88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000		88.05
90.00	09000	CLINIC	1.078628	990	90.00
90.01	09001	GERI PSYCH CLINIC	1.533725	0	90.01
90.02	09002	ORTHO CLINIC	0.957892	0	90.02
91.00	09100	EMERGENCY	0.578613	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.007186	288	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,570,991	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,570,991	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.276805	0	50.00
51.00	05100 RECOVERY ROOM	0.223742	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.821240	0	52.00
53.00	05300 ANESTHESIOLOGY	1.468516	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.235072	8,444	1,985
56.00	05600 RADIOISOTOPE	0.270975	0	56.00
60.00	06000 LABORATORY	0.201569	20,501	4,132
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1.446290	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.096305	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.222205	0	65.00
66.00	06600 PHYSICAL THERAPY	0.472839	287,725	136,048
67.00	06700 OCCUPATIONAL THERAPY	0.386275	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.824626	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.007516	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.216986	5,395	1,171
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.422302	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.184067	46,004	8,468
73.01	07301 CARDIAC REHAB	1.431565	0	73.01
73.02	07302 WOUND CARE	1.979420	0	73.02
73.03	07303 SLEEP LAB	0.321607	0	73.03
73.04	03950 DIETARY EDUCATION	1.207291	0	73.04
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC - PAXTON CLINIC	0.000000		88.00
88.01	08801 RHC II -ONARGA CLINIC	0.000000		88.01
88.02	08802 RHC III - FORREST CLINIC	0.000000		88.02
88.03	08803 RHC IV - HOOPESTON	0.000000		88.03
88.04	08804 RHC V - FARMER CITY	0.000000		88.04
88.05	08805 RHC VI - GIBSON CITY	0.000000		88.05
90.00	09000 CLINIC	1.078628	0	90.00
90.01	09001 GERI PSYCH CLINIC	1.533725	0	90.01
90.02	09002 ORTHO CLINIC	0.957892	0	90.02
91.00	09100 EMERGENCY	0.578613	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.007186	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		368,069	151,804
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		368,069	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,352,414 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)			7,352,414 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 charge basis 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)			7,425,938 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)			56,965 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,874,644 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)			3,494,329 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)			3,494,329 30.00
31.00	Primary payer payments			356 31.00
32.00	Subtotal (line 30 minus line 31)			3,493,973 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)			585,202 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			585,202 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			585,202 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			4,079,175 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)			4,079,175 40.00
41.00	Interim payments			4,284,946 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)			-205,771 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 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: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/26/2013 6:35 pm
	Title XVIII	Hospital	Cost
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)	0	112.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/26/2013 6:35 pm
		Component CCN: 145979	Title XVIII	Skilled Nursing Facility PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		311	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		311	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,692	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)		1,692	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 charge basis 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)		1,692	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,381	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)		311	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)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			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)		311	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)		311	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		311	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		311	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		311	40.00
41.00	Interim payments		320	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)		-9	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/26/2013 6:35 pm
	Title XVIII	Skilled Nursing Facility	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141317

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

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2013 6:35 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		3,969,786		4,206,891	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		20,999		204,506	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	06/15/2012	172,904		0	3.01	
3.02		09/25/2012	25,498		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	06/15/2012	100,336	3.50	
3.51			0	09/25/2012	26,115	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)		198,402		-126,451	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)		4,189,187		4,284,946	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		645,948		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		205,771	6.02	
7.00	Total Medicare program liability (see instructions)		4,835,135		4,079,175	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: 141317

Period:

Worksheet E-1

Component CCN: 14Z317

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

Part I
Date/Time Prepared:
2/26/2013 6:35 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		1,455,890		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		0		0	3.01
3.02			0		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	09/25/2012	341		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)		-341		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)		1,455,549		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		53,229		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,508,778		0	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: 141317
Component CCN: 145979

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

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2013 6:35 pm
PPS

Title XVIII

Skilled Nursing Facility

		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					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		251,394		320	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		0		0	3.01
3.02			0		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)		0		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)		251,394		320	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		9	6.02
7.00	Total Medicare program liability (see instructions)		251,394		311	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet E-1 Part II Date/Time Prepared: 2/26/2013 6:35 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			769 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,278 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			18 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,427 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			107,140,971 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,941,721 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			130,198 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			96,848 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			101,620 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			-4,772 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet E-2
Component CCN: 14Z317		Date/Time Prepared: 2/26/2013 6:35 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)	1,140,215	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)	383,212	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	895	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)	1,523,427	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,523,427	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)	1,523,427	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	14,649	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)	1,508,778	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)	1,508,778	0	19.00
20.00	Interim payments	1,455,549	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)	53,229	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part V Date/Time Prepared: 2/26/2013 6:35 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		5,080,862	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)		5,080,862	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		5,131,671	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)		5,131,671	19.00
20.00	Deductibles (exclude professional component)		336,716	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		4,794,955	22.00
23.00	Coinsurance		283	23.00
24.00	Subtotal (line 22 minus line 23)		4,794,672	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		40,463	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		40,463	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		40,463	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		4,835,135	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)		4,835,135	30.00
31.00	Interim payments		4,189,187	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)		645,948	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		314,395	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		314,395	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		63,001	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		251,394	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		251,394	15.00
16.00	Interim payments		251,394	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 2/26/2013 6:35 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 2/26/2013 6:35 pm
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 141317

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

Worksheet G

Date/Time Prepared:
2/26/2013 6:35 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	563,131	0	0	0	1.00
2.00	Temporary investments	4,714,828	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,087,807	0	0	0	4.00
5.00	Other receivable	987,767	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	666,772	0	0	0	7.00
8.00	Prepaid expenses	452,265	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)	19,472,570	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,647,533	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	19,647,533	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,431,484	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	561,791	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,993,275	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,113,378	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,012,426	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,757,164	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	404,780	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	0	0	0	0	43.00
44.00	Other current liabilities	936,246	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,110,616	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,642,557	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	137,127	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,779,684	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,890,300	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,223,078				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	24,223,078	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,113,378	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141317

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

Worksheet G-1

Date/Time Prepared:
2/26/2013 6:35 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		21,862,119	
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,360,959			2.00
3.00	Total (sum of line 1 and line 2)		24,223,078		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		24,223,078		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,223,078		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141317

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

Worksheet G-1

Date/Time Prepared:
2/26/2013 6:35 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141317

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2013 6:35 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,084,804		7,084,804	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	265,333		265,333	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	2,439,291		2,439,291	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,789,428		9,789,428	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	102,320		102,320	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)	102,320		102,320	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,891,748		9,891,748	17.00
18.00	Ancillary services	24,988,630	61,947,901	86,936,531	18.00
19.00	Outpatient services	217,262	10,817,204	11,034,466	19.00
20.00	RHC - PAXTON CLINIC	0	3,580,477	3,580,477	20.00
20.01	RHC II -ONARGA CLINIC	0	464,475	464,475	20.01
20.02	RHC III - FORREST CLINIC	0	1,699,026	1,699,026	20.02
20.03	RHC IV - HOOPESTON	0	332,625	332,625	20.03
20.04	RHC V - FARMER CITY	0	430,452	430,452	20.04
20.05	RHC VI - GIBSON CITY	0	784,192	784,192	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	3,707,306	3,707,306	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	1,291,569	1,291,569	27.00
27.01		0	0	0	27.01
27.02		0	0	0	27.02
27.03		0	0	0	27.03
27.22		0	0	0	27.22
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	35,097,640	85,055,227	120,152,867	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		58,137,940		29.00
30.00	BAD DEBTS	2,848,689			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)		2,848,689		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)		60,986,629		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141317

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

Worksheet G-3

Date/Time Prepared:
2/26/2013 6:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	120,152,867	1.00
2.00	Less contractual allowances and discounts on patients' accounts	60,894,655	2.00
3.00	Net patient revenues (line 1 minus line 2)	59,258,212	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,986,629	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,728,417	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	481,600	6.00
7.00	Income from investments	84,011	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	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,959,437	24.00
24.01	GRANT INCOME	1,268,416	24.01
24.02	REALIZED GAIN	43,481	24.02
24.03	UNREALIZED GAIN	252,428	24.03
24.04	ROUNDING	3	24.04
24.05		0	24.05
24.06		0	24.06
24.07		0	24.07
24.08		0	24.08
24.09		0	24.09
25.00	Total other income (sum of lines 6-24)	4,089,376	25.00
26.00	Total (line 5 plus line 25)	2,360,959	26.00
27.00		0	27.00
27.01		0	27.01
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)	2,360,959	29.00

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

Provider CCN: 141317

Period: From 10/01/2011

Worksheet M-1

Component CCN: 143408

To 09/30/2012

Date/Time Prepared: 2/26/2013 6:35 pm

				Rural Health Clinic (RHC) I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	Trials Balance (col. 3 + col. 4)	5.00
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,322,928	0	1,322,928	0	1,322,928	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	173,799	0	173,799	0	173,799	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	254,887	0	254,887	0	254,887	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	1,751,614	0	1,751,614	0	1,751,614	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	219,199	219,199	0	219,199	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	219,199	219,199	0	219,199	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,751,614	219,199	1,970,813	0	1,970,813	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	522,001	835,916	1,357,917	123,134	1,481,051	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	522,001	835,916	1,357,917	123,134	1,481,051	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,273,615	1,055,115	3,328,730	123,134	3,451,864	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
	6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-192,864	1,130,064	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	173,799	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	254,887	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)	-192,864	1,558,750	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	219,199	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	219,199	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-192,864	1,777,949	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-227,700	1,253,351	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-227,700	1,253,351	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-420,564	3,031,300	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1 Date/Time Prepared: 2/26/2013 6:35 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	209,603	0	209,603	0	209,603	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	77,675	0	77,675	0	77,675	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	287,278	0	287,278	0	287,278	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	27,380	27,380	0	27,380	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	27,380	27,380	0	27,380	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	287,278	27,380	314,658	0	314,658	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	18,765	93,868	112,633	9,625	122,258	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	18,765	93,868	112,633	9,625	122,258	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	306,043	121,248	427,291	9,625	436,916	32.00

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

Provider CCN: 141317

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

Worksheet M-1

Component CCN: 143440

Date/Time Prepared:
2/26/2013 6:35 pm

Rural Health
Clinic (RHC) II

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	209,603	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	77,675	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	287,278	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	27,380	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	27,380	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	314,658	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-910	121,348	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-910	121,348	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-910	436,006	32.00

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

Provider CCN: 141317

Period: From 10/01/2011

Worksheet M-1

Component CCN: 148505

To 09/30/2012

Date/Time Prepared: 2/26/2013 6:35 pm

		Rural Health Clinic (RHC) III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	500,492	0	500,492	0	500,492
2.00	Physician Assistant	110,125	0	110,125	0	110,125
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	53,389	0	53,389	0	53,389
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1-9)	664,006	0	664,006	0	664,006
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0
15.00	Medical Supplies	0	145,905	145,905	0	145,905
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15-20)	0	145,905	145,905	0	145,905
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	664,006	145,905	809,911	0	809,911
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	175,061	290,845	465,906	20,340	486,246
31.00	Total Facility Overhead (sum of lines 29 and 30)	175,061	290,845	465,906	20,340	486,246
32.00	Total facility costs (sum of lines 22, 28 and 31)	839,067	436,750	1,275,817	20,340	1,296,157

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

Provider CCN: 141317
Component CCN: 148505

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

Worksheet M-1
Date/Time Prepared:
2/26/2013 6:35 pm
Rural Health Clinic (RHC) III
Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	500,492	1.00
2.00	Physician Assistant	0	110,125	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	53,389	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	664,006	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	145,905	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	145,905	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	809,911	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-102,677	383,569	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-102,677	383,569	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-102,677	1,193,480	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141317 Component CCN: 148515	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1 Date/Time Prepared: 2/26/2013 6:35 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) IV Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	223,615	0	223,615	0	223,615	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	128,954	0	128,954	0	128,954	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	352,569	0	352,569	0	352,569	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	21,664	21,664	0	21,664	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	21,664	21,664	0	21,664	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	352,569	21,664	374,233	0	374,233	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	18,195	156,651	174,846	-18,306	156,540	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	18,195	156,651	174,846	-18,306	156,540	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	370,764	178,315	549,079	-18,306	530,773	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1
	Component CCN: 148515	Rural Health Clinic (RHC) IV	Date/Time Prepared: 2/26/2013 6:35 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	223,615	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	128,954	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	352,569	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	21,664	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	21,664	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	374,233	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-15,600	140,940	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-15,600	140,940	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-15,600	515,173	32.00

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

Provider CCN: 141317
Component CCN: 148517

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

Worksheet M-1
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				Rural Health Clinic (RHC) V			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
		Trial Balance (col. 3 + col. 4)					
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	196,512	0	196,512	0	196,512	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	96,038	0	96,038	0	96,038	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	45,388	0	45,388	0	45,388	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	337,938	0	337,938	0	337,938	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	27,933	27,933	0	27,933	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	27,933	27,933	0	27,933	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	337,938	27,933	365,871	0	365,871	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	13,455	131,338	144,793	70,592	215,385	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	13,455	131,338	144,793	70,592	215,385	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	351,393	159,271	510,664	70,592	581,256	32.00

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

Provider CCN: 141317

Period: From 10/01/2011

Worksheet M-1

Component CCN: 148517

To 09/30/2012

Date/Time Prepared: 2/26/2013 6:35 pm

Rural Health Clinic (RHC) V

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	196,512	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	96,038	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	45,388	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	337,938	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	27,933	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	27,933	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	365,871	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-27,777	187,608	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-27,777	187,608	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-27,777	553,479	32.00

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

Provider CCN: 141317
Component CCN: 148516

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

Worksheet M-1
Date/Time Prepared:
2/26/2013 6:35 pm

				Rural Health Clinic (RHC) VI			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
		Trial Balance (col. 3 + col. 4)					
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	172,352	0	172,352	0	172,352	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	67,308	0	67,308	0	67,308	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	49,396	0	49,396	0	49,396	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	289,056	0	289,056	0	289,056	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	9,756	9,756	0	9,756	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	9,756	9,756	0	9,756	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	289,056	9,756	298,812	0	298,812	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	231,997	124,981	356,978	-4,931	352,047	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	231,997	124,981	356,978	-4,931	352,047	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	521,053	134,737	655,790	-4,931	650,859	32.00

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

Provider CCN: 141317

Period: From 10/01/2011

Worksheet M-1

Component CCN: 148516

To 09/30/2012

Date/Time Prepared: 2/26/2013 6:35 pm

Rural Health Clinic (RHC) VI

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	172,352	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	67,308	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	49,396	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	289,056	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	9,756	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	9,756	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	298,812	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-23,013	329,034	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-23,013	329,034	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-23,013	627,846	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2 Date/Time Prepared: 2/26/2013 6:35 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						
Posi tions						
1.00	Physician	2.45	14,621	4,200	10,290	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.49	4,701	2,100	5,229	3.00
4.00	Subtotal (sum of lines 1-3)	4.94	19,322		15,519	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	0		0	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)	4.94	19,322			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)				1,777,949	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)				1,777,949	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)				1,253,351	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,595,233	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,848,584	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				2,848,584	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				2,848,584	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				4,626,533	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2 Date/Time Prepared: 2/26/2013 6:35 pm		
		Rural Health Clinic (RHC) II		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	0.03	140	4,200	126	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.41	4,039	2,100	2,961	3.00
4.00	Subtotal (sum of lines 1-3)	1.44	4,179		3,087	4,179
5.00	Visiting Nurse	0.00	0			0
6.00	Clinical Psychologist	0.00	0			0
7.00	Clinical Social Worker	0.00	0			0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0
8.00	Total FTEs and Visits (sum of lines 4-7)	1.44	4,179			4,179
9.00	Physician Services Under Agreements		0			0
					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)				314,658	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)				314,658	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)				121,348	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				198,113	15.00
16.00	Total overhead (sum of lines 14 and 15)				319,461	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				319,461	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				319,461	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				634,119	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2		
		Component CCN: 148505		Date/Time Prepared: 2/26/2013 6:35 pm		
			Rural Health Clinic (RHC) III	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	0.96	3,413	4,200	4,032	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.80	2,260	2,100	1,680	3.00
4.00	Subtotal (sum of lines 1-3)	1.76	5,673		5,712	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	0		0	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)	1.76	5,673		5,712	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)				809,911	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)				809,911	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)				383,569	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				550,773	15.00
16.00	Total overhead (sum of lines 14 and 15)				934,342	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				934,342	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				934,342	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,744,253	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141317 Component CCN: 148515	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2 Date/Time Prepared: 2/26/2013 6:35 pm		
			Rural Health Clinic (RHC) IV	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	0.52	1,138	4,200	2,184	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.34	968	2,100	714	3.00
4.00	Subtotal (sum of lines 1-3)	0.86	2,106		2,898	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	0		0	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)	0.86	2,106		2,898	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)				374,233	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)				374,233	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)				140,940	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				263,728	15.00
16.00	Total overhead (sum of lines 14 and 15)				404,668	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				404,668	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				404,668	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				778,901	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141317 Component CCN: 148517	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2 Date/Time Prepared: 2/26/2013 6:35 pm
			Rural Health Clinic (RHC) V	

	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						
Posi tions						
1.00	Physician	0.75	1,662	4,200	3,150	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.86	749	2,100	1,806	3.00
4.00	Subtotal (sum of lines 1-3)	1.61	2,411		4,956	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	0		0	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)	1.61	2,411		4,956	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)				365,871	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)				365,871	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)				187,608	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				256,722	15.00
16.00	Total overhead (sum of lines 14 and 15)				444,330	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				444,330	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				444,330	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				810,201	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141317 Component CCN: 148516	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2 Date/Time Prepared: 2/26/2013 6:35 pm
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			Rural Health Clinic (RHC) VI	
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	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	0.58	2,784	4,200	2,436	1.00
2.00	Physician Assistant	0.25	1,427	2,100	525	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1-3)	0.83	4,211		2,961	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	0		0	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)	0.83	4,211			8.00
9.00	Physician Services Under Agreements		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)			298,812	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)			298,812	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)			329,034	14.00
15.00	Parent provider overhead allocated to facility (see instructions)			272,248	15.00
16.00	Total overhead (sum of lines 14 and 15)			601,282	16.00
17.00	Allowable GME overhead (see instructions)			0	17.00
18.00	Subtract line 17 from line 16			601,282	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)			601,282	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)			900,094	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3
		Component CCN: 143408		Date/Time Prepared: 2/26/2013 6:35 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)		4,626,533	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		69,897	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,556,636	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		19,322	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)		19,322	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		235.83	7.00
		Calculation of Limit (1)		
		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)	235.83	235.83	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,997	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,178,443	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) *		1,178,443	16.00
16.01	Total program charges (see instructions)(from contractor's records)		741,719	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		17,685	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		28,098	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.)		876,798	16.04
16.05	Total program cost (see instructions)		904,896	16.05
17.00	Primary payer amounts		490	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		54,347	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		904,406	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,661	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		922,067	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)		922,067	26.00
27.00	Interim payments		947,067	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)		-25,000	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3 Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Rural Health Clinic (RHC) II	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)		634,119	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		12,063	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		622,056	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,179	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)		4,179	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		148.85	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on 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)	148.85	148.85	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	256	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	38,106	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) *		38,106	16.00
16.01	Total program charges (see instructions)(from contractor's records)		42,152	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,914	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,730	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.)		26,907	16.04
16.05	Total program cost (see instructions)		28,637	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,742	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		28,637	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		805	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		29,442	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)		29,442	26.00
27.00	Interim payments		44,227	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)		-14,785	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		284	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3
		Component CCN: 148505		Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Rural Health Clinic (RHC) III	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)		1,744,253	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		14,118	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,730,135	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,712	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)		5,712	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		302.89	7.00
		Calculation of Limit (1)		
		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)	302.89	302.89	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,078	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	326,515	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) *		326,515	16.00
16.01	Total program charges (see instructions)(from contractor's records)		177,473	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,462	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,729	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.)		241,248	16.04
16.05	Total program cost (see instructions)		254,977	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,226	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		254,977	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,174	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		261,151	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)		261,151	26.00
27.00	Interim payments		167,452	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)		93,699	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3
		Component CCN: 148515		Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Rural Health Clinic (RHC) IV	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)		778,901	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		8,271	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		770,630	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,898	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)		2,898	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		265.92	7.00
		Calculation of Limit (1)		
		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)	265.92	265.92	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	629	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	167,264	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) *		167,264	16.00
16.01	Total program charges (see instructions)(from contractor's records)		114,734	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,252	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,741	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.)		123,794	16.04
16.05	Total program cost (see instructions)		128,535	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,780	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		128,535	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,402	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		131,937	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)		131,937	26.00
27.00	Interim payments		65,176	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)		66,761	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		91	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3	
		Component CCN: 148517		Date/Time Prepared: 2/26/2013 6:35 pm	
		Title XVIII	Rural Health Clinic (RHC) V		
				1.00	
DETERMINATION OF RATE FOR RHC/FQHC SERVICES					
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		810,201		1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		14,349		2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		795,852		3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,956		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)		4,956		6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		160.58		7.00
		Calculation of Limit (1)			
		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)	160.58	160.58		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	220		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	35,328		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) *		35,328		16.00
16.01	Total program charges (see instructions)(from contractor's records)		37,582		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,305		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,807		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.)		21,080		16.04
16.05	Total program cost (see instructions)		28,887		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,171		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		28,887		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,111		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		30,998		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)		30,998		26.00
27.00	Interim payments		18,712		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)		12,286		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141317	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3
		Component CCN: 148516		Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Rural Health Clinic (RHC) VI	
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		900,094	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		14,390	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		885,704	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,211	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)		4,211	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		210.33	7.00
		Calculation of Limit (1)		
		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)	210.33	210.33	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	129	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	27,133	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) *		27,133	16.00
16.01	Total program charges (see instructions)(from contractor's records)		22,774	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,718	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,238	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.)		18,677	16.04
16.05	Total program cost (see instructions)		21,915	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		549	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		21,915	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		407	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		22,322	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)		22,322	26.00
27.00	Interim payments		4,731	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)		17,591	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2011 To 09/30/2012	Worksheet M-4 Date/Time Prepared: 2/26/2013 6:35 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)	1,558,750	1,558,750	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001250	0.004218	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,948	6,575	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	9,897	8,441	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	11,845	15,016	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,777,949	1,777,949	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	2,848,584	2,848,584	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006662	0.008446	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	18,977	24,059	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	30,822	39,075	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	201	678	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	153.34	57.63	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	37	208	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,674	11,987	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)		69,897	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)		17,661	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2011 To 09/30/2012	Worksheet M-4 Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	287,278	287,278	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001388	0.004873	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	399	1,400	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,216	1,971	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,615	3,371	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	314,658	314,658	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	319,461	319,461	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008311	0.010713	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,655	3,422	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,270	6,793	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	45	158	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	117.11	42.99	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	16	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	117	688	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)		12,063	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)		805	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141317 Component CCN: 148505	Period: From 10/01/2011 To 09/30/2012	Worksheet M-4 Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	664,006	664,006	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000267	0.003395	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	177	2,254	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	985	3,139	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,162	5,393	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	809,911	809,911	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	934,342	934,342	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001435	0.006659	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,341	6,222	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,503	11,615	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	20	254	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	125.15	45.73	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	19	83	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,378	3,796	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)		14,118	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)		6,174	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141317 Component CCN: 148515	Period: From 10/01/2011 To 09/30/2012	Worksheet M-4 Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	352,569	352,569	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000591	0.003605	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	208	1,271	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	985	1,510	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,193	2,781	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	374,233	374,233	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	404,668	404,668	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003188	0.007431	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,290	3,007	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,483	5,788	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	20	122	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	124.15	47.44	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	56	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	745	2,657	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)		8,271	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)		3,402	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141317 Component CCN: 148517	Period: From 10/01/2011 To 09/30/2012	Worksheet M-4 Date/Time Prepared: 2/26/2013 6:35 pm
		Title XVIII	Rural Health Clinic (RHC) V	
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	337,938	337,938	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002267	0.004455	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	766	1,506	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,807	1,401	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,573	2,907	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	365,871	365,871	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	444,330	444,330	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.009766	0.007945	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,339	3,530	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	7,912	6,437	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	57	112	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	138.81	57.47	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	9	15	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,249	862	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)		14,349	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)		2,111	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317
Component CCN: 148516

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

Worksheet M-4
Date/Time Prepared:
2/26/2013 6:35 pm

Title XVIII

Rural Health
Clinic (RHC) VI

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	289,056	289,056	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001004	0.001291	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	290	373	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,102	1,012	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,392	1,385	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	298,812	298,812	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	601,282	601,282	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011352	0.004635	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,826	2,787	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	10,218	4,172	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	32	41	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	319.31	101.76	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	407	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)		14,390	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)		407	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		776,148	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		06/15/2012	136,614	3.01
3.02		09/25/2012	34,305	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		170,919	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		947,067	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		25,000	6.02
7.00	Total Medicare program liability (see instructions)		922,067	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		40,696	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		06/15/2012	2,784	3.01
3.02		09/25/2012	747	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,531	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		44,227	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		14,785	6.02
7.00	Total Medicare program liability (see instructions)		29,442	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141317 Component CCN: 148505	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		175,225	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		06/15/2012	6,322	3.50
3.51		09/25/2012	1,451	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)		-7,773	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		167,452	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		93,699	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		261,151	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141317 Component CCN: 148515	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		53,865	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		06/15/2012	10,046	3.01
3.02		09/25/2012	1,265	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		11,311	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		65,176	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		66,761	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		131,937	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141317 Component CCN: 148517	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) V	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		18,712	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		18,712	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		12,286	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		30,998	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141317 Component CCN: 148516	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/26/2013 6:35 pm
		Rural Health Clinic (RHC) VI	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		4,731	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		4,731	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		17,591	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		22,322	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00