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: 140137	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/5/2014 8:10 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/5/2014 Time: 8:10 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 GREENVILLE REGIONAL HOSPITAL (140137) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 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

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-117,484	9,141	-1,372	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	1	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	29,386	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		311,101		0	10.00
10.01	RURAL HEALTH CLINIC II	0		0		0	10.01
10.02	RURAL HEALTH CLINIC III	0		0		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		0		0	10.03
10.04	RURAL HEALTH CLINIC V	0		0		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		0		0	10.05
200.00	Total	0	-88,097	320,242	-1,372	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/5/2014 7:51 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 HEALTHCARE DRIVE	PO Box:			1.00
2.00	City: GREENVILLE	State: IL	Zip Code: 62246-1156	County: BOND	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GREENVILLE REGIONAL HOSPITAL	140137	41180	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF	GREENVILLE I/P PSYCH UNIT	14S137	41180	4	01/01/2005	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENVILLE REGIONAL HOSP- SWING BED	14U137	41180		10/03/2001	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAIR OAKS	146022	41180		05/20/2002	N	P	N	9.00
10.00	Hospital-Based NF	FAIR OAKS	146022	41180		05/20/2002	N		O	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	GREENVILLE FAMILY WELLNESS	143491	41180		07/24/2007	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	GREENVILLE FAMILY WELLNESS	143498	41180		07/22/2007	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	GREENVILLE MEDICAL ASSOCIATES	148512	41180		12/01/2010	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	GREENVILLE MEDICAL ASSOCIATES	148513	41180		12/01/2010	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	MCCRACKEN DAWDY HALL FAMILY PRACTICE	148519	41180		09/01/2011	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	MCCRACKEN DAWDY HALL FAMILY PRACTICE	148520	41180		09/01/2011	N	O	N	15.05
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify 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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
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.	3	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	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	538	483	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/5/2014 7:51 am

		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	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		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.	1		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.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	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.	N			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	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/5/2014 7:51 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings		
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/5/2014 7:51 am

		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 associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	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.	Y			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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/5/2014 7:51 am

		1.00	2.00	3.00	
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 5th or 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.	N	86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	523,642	14,880	5,000,000	118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/5/2014 7:51 am

		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 high cost 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)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	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
161.10	CORF		N	N	N	161.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140137	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/5/2014 7:51 am

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					41180	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)	0	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)	0.50	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/5/2014 7:51 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	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		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	03/04/2014	Y	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		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		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		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/5/2014 7:51 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.				N	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.	STEVE	HOWELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4497	STEVE.HOWELL@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 5/5/2014 7:51 am

		Part B Date 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)				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)	03/04/2014			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.				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.				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:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR OF REIMBURSEMENT		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: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 5/5/2014 7:51 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	32	11,680	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		32	11,680	0.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		32	11,680	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	10	3,650		0	19.00
20.00	NURSING FACILITY	45.00	98	35,770		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RHC (Consolidated)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		150				27.00
28.00	Observation Bed Days					0	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)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/5/2014 7:51 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,276	472	2,364			1.00
2.00	HMO and other (see instructions)	24	185				2.00
3.00	HMO IPF Subprovider	22	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	989	0	1,001			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	26			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,265	472	3,391			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		295	443			13.00
14.00	Total (see instructions)	2,265	767	3,834	0.00	244.30	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,767	0	1,899	0.00	15.83	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	607	0	607	0.00	2.32	19.00
20.00	NURSING FACILITY		5,171	8,336	0.00	31.89	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RHC (Consolidated)	9,892	10,872	35,237	0.00	33.15	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	327.49	27.00
28.00	Observation Bed Days		0	181			28.00
29.00	Ambulance Trips	0					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	69	114			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/5/2014 7:51 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	417	238	921	1.00
2.00	HMO and other (see instructions)			8			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	0	417	238	921	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	201	0	215	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RHC (Consolidated)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	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
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 5/5/2014 7:51 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	16,519,161	0	16,519,161	681,200.00	24.25	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	426,914	426,914	4,492.00	95.04	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		2,225,005	0	2,225,005	13,210.70	168.42	5.00
6.00	Non-physician-Part B		768,078	0	768,078	14,555.00	52.77	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,373	58,642	60,015	4,831.00	12.42	9.00
10.00	Excluded area salaries (see instructions)		2,625,029	-58,642	2,566,387	140,885.00	18.22	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		1,119,579	0	1,119,579	18,063.00	61.98	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,000,471	0	3,000,471			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		832,035	0	832,035			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		26,529	0	26,529			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		78,019	0	78,019			22.01
23.00	Physician Part B		85,959	0	85,959			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	158,403	0	158,403	5,339.00	29.67	26.00
27.00	Administrative & General	5.00	2,101,204	0	2,101,204	62,844.00	33.44	27.00
28.00	Administrative & General under contract (see inst.)		218,322	0	218,322	838.65	260.33	28.00
29.00	Maintenance & Repairs	6.00	290,622	0	290,622	12,156.00	23.91	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	117,462	0	117,462	10,409.00	11.28	31.00
32.00	Housekeeping	9.00	368,548	0	368,548	31,382.00	11.74	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	422,035	-218,813	203,222	17,424.52	11.66	34.00
35.00	Dietary under contract (see instructions)		15,122	0	15,122	322.00	46.96	35.00
36.00	Cafeteria	11.00	0	218,813	218,813	18,763.48	11.66	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	561,319	0	561,319	40,775.00	13.77	38.00
39.00	Central Services and Supply	14.00	117,480	0	117,480	6,065.00	19.37	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	429,751	0	429,751	23,398.00	18.37	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 5/5/2014 7:51 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part III Date/Time Prepared: 5/5/2014 7:51 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		13,759,522	-426,914	13,332,608	650,102.95	20.51	1.00
2.00	Excluded area salaries (see instructions)		2,626,402	0	2,626,402	145,716.00	18.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11,133,120	-426,914	10,706,206	504,386.95	21.23	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,119,579	0	1,119,579	18,063.00	61.98	4.00
5.00	Subtotal wage-related costs (see inst.)		3,000,471	0	3,000,471	0.00	28.03	5.00
6.00	Total (sum of lines 3 thru 5)		15,253,170	-426,914	14,826,256	522,449.95	28.38	6.00
7.00	Total overhead cost (see instructions)		4,800,268	0	4,800,268	229,716.65	20.90	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part IV Date/Time Prepared: 5/5/2014 7:51 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	155,957	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)	2,197,624	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	59,800	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	67,267	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	294,390	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	1,113,432	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	134,542	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)	4,023,012	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	305,736	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part V Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-7 | Date/Time Prepared: 5/5/2014 7:51 am

		1.00	2.00	
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		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	30	30	4.00
5.00		RVX	0	24	24	5.00
6.00		RVL	14	33	47	6.00
7.00		RHX	0	7	7	7.00
8.00		RHL	14	10	24	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	61	14	75	12.00
13.00		RUB	23	63	86	13.00
14.00		RUA	236	251	487	14.00
15.00		RVC	20	26	46	15.00
16.00		RVB	53	62	115	16.00
17.00		RVA	159	246	405	17.00
18.00		RHC	0	4	4	18.00
19.00		RHB	9	14	23	19.00
20.00		RHA	0	76	76	20.00
21.00		RMC	8	3	11	21.00
22.00		RMB	0	6	6	22.00
23.00		RMA	0	39	39	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	0	13	13	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	1	5	6	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	6	6	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	8	0	8	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	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	6	6	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	51	51	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	1	0	1	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: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-7 | Date/Time Prepared: 5/5/2014 7:51 am

		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	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		607	989	1,596	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	
	SNF SERVICES			
201.00	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).	41180	41180	201.00

		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	0	0.00		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)	79,012			207.00

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

Provider CCN: 140137 Component CCN: 143491 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 5/5/2014 7:51 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	150 HEALTHCARE DRIVE	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	GREENVILLE	IL	62246	2.00

			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
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	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	19:00	08:00	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. 100-04, 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.		Y	6	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	GREENVILLE FAMILY WELLNESS	143491	14.00
14.01		GREENVILLE FAMILY WELLNESS	143498	14.01
14.02		GREENVILLE MEDICAL ASSOCIATES	148512	14.02
14.03		GREENVILLE MEDICAL ASSOCIATES	148513	14.03
14.04		MCCRACKEN DAWDY HALL FAMILY PRACTICE	148519	14.04
14.05		MCCRACKEN DAWDY HALL FAMILY PRACTICE	148520	14.05

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

Provider CCN: 140137 Component CCN: 143491 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 Date/Time Prepared: 5/5/2014 7:51 am

Rural Health Clinic (RHC) I | Cost

		Y/N	V	XVIII	XIX	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)		0	0	0	0	15.00

		County					
		4.00					
2.00	City, State, Zip Code, County		BOND				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	08:00	17:00	08:00	17:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-10 | Date/Time Prepared: 5/5/2014 7:52 am

		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)	0.440907	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	881,604	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	1,523,418	5.00
6.00	Medicaid charges	10,684,012	6.00
7.00	Medicaid cost (line 1 times line 6)	4,710,656	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)	2,305,634	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,305,634	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	786,422	152,604	939,026	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	346,739	67,284	414,023	21.00
22.00	Partial payment by patients approved for charity care	1,352	5,911	7,263	22.00
23.00	Cost of charity care (line 21 minus line 22)	345,387	61,373	406,760	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)	2,336,388	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	261,887	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,074,501	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	914,662	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,321,422	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,627,056	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,616,787	1,616,787	-239,870	1,376,917	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		620,366	620,366	782,192	1,402,558	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	158,403	4,341,084	4,499,487	0	4,499,487	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,101,204	3,197,534	5,298,738	-75,416	5,223,322	5.00
6.00	00600	MAINTENANCE & REPAIRS	290,622	906,955	1,197,577	0	1,197,577	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	117,462	33,906	151,368	0	151,368	8.00
9.00	00900	HOUSEKEEPING	368,548	82,698	451,246	0	451,246	9.00
10.00	01000	DIETARY	422,035	371,128	793,163	-426,710	366,453	10.00
11.00	01100	CAFETERIA	0	0	0	426,710	426,710	11.00
13.00	01300	NURSING ADMINISTRATION	561,319	57,562	618,881	0	618,881	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	117,480	21,399	138,879	0	138,879	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	429,751	38,239	467,990	0	467,990	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	513,917	513,917	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,407,427	642,872	2,050,299	-383,236	1,667,063	30.00
40.00	04000	SUBPROVIDER - IPF	674,885	122,426	797,311	0	797,311	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	309,660	309,660	43.00
44.00	04400	SKILLED NURSING FACILITY	1,373	0	1,373	69,880	71,253	44.00
45.00	04500	NURSING FACILITY	884,212	165,564	1,049,776	-69,880	979,896	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	678,516	212,729	891,245	0	891,245	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	73,576	73,576	52.00
53.00	05300	ANESTHESIOLOGY	426,914	113,587	540,501	-513,917	26,584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	566,207	613,390	1,179,597	0	1,179,597	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	562,720	881,009	1,443,729	0	1,443,729	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	279,006	11,603	290,609	-91,227	199,382	65.00
66.00	06600	PHYSICAL THERAPY	0	679,656	679,656	-250,182	429,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	153,162	153,162	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	97,020	97,020	68.00
69.00	06900	ELECTROCARDIOLOGY	0	54,594	54,594	91,227	145,821	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	425,638	425,638	0	425,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	65,597	65,597	0	65,597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	421,599	1,050,717	1,472,316	0	1,472,316	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	132,317	89,100	221,417	0	221,417	75.01
76.97	07697	CARDIAC REHABILITATION	12,883	791	13,674	0	13,674	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,274,236	926,996	5,201,232	0	5,201,232	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	73,003	7,497	80,500	0	80,500	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	491,107	829,649	1,320,756	0	1,320,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	556,417	76,936	633,353	0	633,353	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		466,906	466,906	-466,906	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,009,646	18,724,915	34,734,561	0	34,734,561	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	417,258	225,617	642,875	0	642,875	192.00
193.00	19300	NONPAID WORKERS	31,330	140,679	172,009	0	172,009	193.00
194.00	07950	EMERALD POINT	60,927	344,206	405,133	0	405,133	194.00
200.00		TOTAL (SUM OF LINES 118-199)	16,519,161	19,435,417	35,954,578	0	35,954,578	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/5/2014 7:51 am

		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	-89,589	1,287,328		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-15,449	1,387,109		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,154,438	3,345,049		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-322,500	4,900,822		5.00
6.00	00600	MAINTENANCE & REPAIRS	-11,970	1,185,607		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	151,368		8.00
9.00	00900	HOUSEKEEPING	-27	451,219		9.00
10.00	01000	DIETARY	-42,945	323,508		10.00
11.00	01100	CAFETERIA	-130,038	296,672		11.00
13.00	01300	NURSING ADMINISTRATION	-10,621	608,260		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	138,879		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,676	449,314		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-513,917	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-350,773	1,316,290		30.00
40.00	04000	SUBPROVIDER - IPF	-99,147	698,164		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	309,660		43.00
44.00	04400	SKILLED NURSING FACILITY	0	71,253		44.00
45.00	04500	NURSING FACILITY	0	979,896		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	891,245		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	73,576		52.00
53.00	05300	ANESTHESIOLOGY	0	26,584		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-14,742	1,164,855		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-10,742	1,432,987		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	-591	198,791		65.00
66.00	06600	PHYSICAL THERAPY	0	429,474		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	153,162		67.00
68.00	06800	SPEECH PATHOLOGY	0	97,020		68.00
69.00	06900	ELECTROCARDIOLOGY	-48,664	97,157		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-888	424,750		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	65,597		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-277,991	1,194,325		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	-24,000	197,417		75.01
76.97	07697	CARDIAC REHABILITATION	0	13,674		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-364,986	4,836,246		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0		88.05
90.00	09000	CLINIC	-4,380	76,120		90.00
90.01	09001	WELLNESS LINK	0	0		90.01
91.00	09100	EMERGENCY	-802,624	518,132		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-19,176	614,177		95.00
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,328,874	30,405,687		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	642,875		192.00
193.00	19300	NONPAID WORKERS	0	172,009		193.00
194.00	07950	EMERALD POINT	0	405,133		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,328,874	31,625,704		200.00

RECLASSIFICATIONS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/5/2014 7:52 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CRNA FEES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	426,914	87,003		1.00
	TOTALS		426,914	87,003		
	B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	218,813	207,897		1.00
	TOTALS		218,813	207,897		
	C - DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	739,770		1.00
	TOTALS		0	739,770		
	D - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	91,227	0		1.00
	TOTALS		91,227	0		
	E - OB EXPENSE					
1.00	NURSERY	43.00	266,480	43,180		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	63,316	10,260		2.00
	TOTALS		329,796	53,440		
	F - CONTRACT THERAPY EXPENSE					
1.00	OCCUPATIONAL THERAPY	67.00	0	153,162		1.00
2.00	SPEECH PATHOLOGY	68.00	0	97,020		2.00
	TOTALS		0	250,182		
	G - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	57,596		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	17,820		2.00
	TOTALS		0	75,416		
	H - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	442,304		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	24,602		2.00
	TOTALS		0	466,906		
	I - SKILLED NURSING EXPENSE					
1.00	SKILLED NURSING FACILITY	44.00	58,642	11,238		1.00
	TOTALS		58,642	11,238		
500.00	Grand Total: Increases		1,125,392	1,891,852		500.00

RECLASSIFICATIONS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/5/2014 7:52 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CRNA FEES						
1.00	ANESTHESIOLOGY	53.00	426,914	87,003	0		1.00
	TOTALS		426,914	87,003			
	B - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	218,813	207,897	0		1.00
	TOTALS		218,813	207,897			
	C - DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	739,770	9		1.00
	TOTALS		0	739,770			
	D - EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	91,227	0	0		1.00
	TOTALS		91,227	0			
	E - OB EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	329,796	53,440	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		329,796	53,440			
	F - CONTRACT THERAPY EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	250,182	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	250,182			
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,416	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	75,416			
	H - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	466,906	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	466,906			
	I - SKILLED NURSING EXPENSE						
1.00	NURSING FACILITY	45.00	58,642	11,238	0		1.00
	TOTALS		58,642	11,238			
500.00	Grand Total: Decreases		1,125,392	1,891,852			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 5/5/2014 7:51 am

		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	0	0	0	0	0	1.00
2.00	Land Improvements	1,218,392	0	0	0	20,865	2.00
3.00	Buildings and Fixtures	30,840,314	289,080	0	289,080	203,908	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,811,205	561,481	0	561,481	433,890	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,869,911	850,561	0	850,561	658,663	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	41,869,911	850,561	0	850,561	658,663	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	1,197,527	0	2.00
3.00	Buildings and Fixtures	30,925,486	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,938,796	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,061,809	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	42,061,809	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	SUMMARY OF CAPITAL: 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	1,616,787	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	620,366	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,237,153	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: 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	1,616,787	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	620,366	2.00
3.00	Total (sum of lines 1-2)	0	2,237,153	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	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	32,123,013	0	32,123,013	0.763710	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	9,938,796	0	9,938,796	0.236290	0	2.00
3.00	Total (sum of lines 1-2)	42,061,809	0	42,061,809	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	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	926,393	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,352,417	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,278,810	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		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	303,339	57,596	0	0	1,287,328	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	16,872	17,820	0	0	1,387,109	2.00
3.00	Total (sum of lines 1-2)	320,211	75,416	0	0	2,674,437	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-138,965	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-7,730	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-10,621	NURSING ADMINISTRATION	13.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,804,209			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-11,590	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	121,476			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-130,038	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-272,155	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-18,676	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-3,846	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	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	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-513,917	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	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
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	COUNTRY CLUB DUES	A	-630	ADMINISTRATIVE & GENERAL	5.00	0	33.00
35.00	CRNA RELATED BENEFITS	A	-111,870	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
44.00	LOBBYING EXPENSE	A	-14,016	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	ADVERTISING OFFSET SALARY	A	-19,414	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	ADVERTISING OFFSET OTHER EXP	A	-186,699	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	AMBULANCE REIMBURSEMENT	B	-19,176	AMBULANCE SERVICES	95.00	0	45.02
45.03	HEALTH FAIR TESTS INCOME-LAB	A	-90,269	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04			0		0.00	0	45.04
45.05			0		0.00	0	45.05
45.06	VENDING MACHINES	B	-27	HOUSEKEEPING	9.00	0	45.06
45.07	VARIOUS ADMINISTRATIVE	B	-380	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	CLINIC PROPERTY RENTAL	B	-72,100	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.08
45.09			0		0.00	0	45.09
45.10	RENT	B	-3,000	RADIOLOGY-DIAGNOSTIC	54.00	0	45.10
45.11	EDUCATION SEMINARS	B	-1,430	RURAL HEALTH CLINIC	88.00	0	45.11
45.12	ADVERTISING OFFSET-EMPLOYEE BENEFITS	A	-5,087	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.12
45.13			0		0.00	0	45.13
45.14	GREEN TEAM SAVINGS	B	-25	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.16	TELEPHONE SERVICE	A	-11,970	MAINTENANCE & REPAIRS	6.00	0	45.16
45.17	TELEPHONE SERVICE	A	-7,719	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	45.17
45.23	NUTRITION COUNSEL REVENUE	B	-4,842	DIETARY	10.00	0	45.23
45.25	BARBER AND BEAUTY EXPENSE	A	-1,767	ADMINISTRATIVE & GENERAL	5.00	0	45.25
45.27			0		0.00	0	45.27
45.28			0		0.00	0	45.28
45.29			0		0.00	0	45.29
45.30	CATERING REVENUE	B	-34,257	DIETARY	10.00	0	45.30
45.31			0		0.00	0	45.31
45.32			0		0.00	0	45.32
45.33	MISC SUPPLY REVENUE	B	-5,836	DRUGS CHARGED TO PATIENTS	73.00	0	45.33
45.34	MISC SUPPLY REVENUE	B	-888	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	45.34
45.35	SELF INSURANCE ADJUSTMENT	A	-942,209	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.35
45.36			0		0.00	0	45.36
45.37			0		0.00	0	45.37
45.38	COMMUNITY HEALTH EVENTS INCOME	B	-4,992	LABORATORY	60.00	0	45.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,328,874				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 5/5/2014 7:51 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	GFW RHC LEASE EXPENSE	26,911	14,400	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	GMA RHC LEASE EXPENSE	26,935	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	GFW-MG RHC LEASE EXPENSE	9,863	0	3.00
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	GMA-KEYESPORT RHC LEASE	280	0	4.00
4.01	1.00	NEW CAP REL COSTS-BLDG & FIX	MDH RHC LEASE EXPENSE	67,298	0	4.01
4.02	1.00	NEW CAP REL COSTS-BLDG & FIX	MDH POKEY RHC LEASE EXPENSE	4,589	0	4.02
5.00	0		0	135,876	14,400	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	GREENVILLE REGI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140137	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-1 Date/Time Prepared: 5/5/2014 7:51 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	12,511	9		1.00
2.00	26,935	9		2.00
3.00	9,863	9		3.00
4.00	280	9		4.00
4.01	67,298	9		4.01
4.02	4,589	9		4.02
5.00	121,476			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 5/5/2014 7:52 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	152	152	0	0	0	1.00
2.00	90.00	CLINIC	4,380	4,380	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	48,664	48,664	0	0	0	3.00
4.00	91.00	EMERGENCY	802,624	802,624	0	0	0	4.00
5.00	60.00	LABORATORY	5,750	5,750	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	99,147	99,147	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	591	591	0	0	0	7.00
8.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	95,272	95,272	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	9,300	9,300	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	350,773	350,773	0	0	0	10.00
11.00	50.00	OPERATING ROOM	0	0	0	0	0	11.00
12.00	75.01	SNR DAY TREATMENT- WHITE OAKS	24,000	24,000	0	0	0	12.00
13.00	88.00	RURAL HEALTH CLINIC	363,556	363,556	0	0	0	13.00
200.00			1,804,209	1,804,209	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	10.00
11.00	50.00	OPERATING ROOM	0	0	0	0	0	11.00
12.00	75.01	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	12.00
13.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	13.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	152		1.00
2.00	90.00	CLINIC	0	0	0	4,380		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	48,664		3.00
4.00	91.00	EMERGENCY	0	0	0	802,624		4.00
5.00	60.00	LABORATORY	0	0	0	5,750		5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	99,147		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	591		7.00
8.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	95,272		8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	9,300		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	350,773		10.00
11.00	50.00	OPERATING ROOM	0	0	0	0		11.00
12.00	75.01	SNR DAY TREATMENT- WHITE OAKS	0	0	0	24,000		12.00
13.00	88.00	RURAL HEALTH CLINIC	0	0	0	363,556		13.00
200.00			0	0	0	1,804,209		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,287,328	1,287,328				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,387,109		1,387,109			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,345,049	1,548	1,668	3,348,265		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,900,822	75,505	81,358	448,578	5,506,263	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,185,607	86,737	93,460	62,622	1,428,426	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	151,368	15,401	16,595	25,310	208,674	8.00
9.00	00900	HOUSEKEEPING	451,219	15,544	16,749	79,414	562,926	9.00
10.00	01000	DIETARY	323,508	36,460	39,286	43,790	443,044	10.00
11.00	01100	CAFETERIA	296,672	11,220	12,090	47,149	367,131	11.00
13.00	01300	NURSING ADMINISTRATION	608,260	40,736	43,894	120,951	813,841	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	138,879	84,117	90,637	25,314	338,947	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	449,314	23,679	25,515	92,601	591,109	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,316,290	111,370	120,002	232,205	1,779,867	30.00
40.00	04000	SUBPROVIDER - IPF	698,164	47,764	51,466	145,422	942,816	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	309,660	2,847	3,067	57,420	372,994	43.00
44.00	04400	SKILLED NURSING FACILITY	71,253	26,109	28,133	12,932	138,427	44.00
45.00	04500	NURSING FACILITY	979,896	0	0	177,891	1,157,787	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	891,245	98,089	105,692	146,205	1,241,231	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,576	10,625	11,448	13,643	109,292	52.00
53.00	05300	ANESTHESIOLOGY	26,584	977	1,052	0	28,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,164,855	73,838	79,561	122,005	1,440,259	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,432,987	30,231	32,574	121,253	1,617,045	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	198,791	27,217	29,327	40,462	295,797	65.00
66.00	06600	PHYSICAL THERAPY	429,474	34,495	37,169	0	501,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,162	12,674	13,656	0	179,492	67.00
68.00	06800	SPEECH PATHOLOGY	97,020	8,028	8,650	0	113,698	68.00
69.00	06900	ELECTROCARDIOLOGY	97,157	1,525	1,643	19,657	119,982	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	424,750	0	0	0	424,750	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,597	0	0	0	65,597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,194,325	23,703	25,541	90,845	1,334,414	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	197,417	21,202	22,845	28,511	269,975	75.01
76.97	07697	CARDIAC REHABILITATION	13,674	4,717	5,082	2,776	26,249	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,836,246	247,789	266,997	842,658	6,193,690	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	76,120	46,478	50,080	15,730	188,408	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	518,132	27,205	29,314	103,237	677,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	614,177	18,903	20,368	119,895	773,343	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,405,687	1,266,733	1,364,919	3,238,476	30,253,113	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	642,875	13,996	15,080	89,910	761,861	192.00
193.00	19300	NONPAID WORKERS	172,009	6,599	7,110	6,751	192,469	193.00
194.00	07950	EMERALD POINT	405,133	0	0	13,128	418,261	194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	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)	31,625,704	1,287,328	1,387,109	3,348,265	31,625,704	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		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 DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,506,263					5.00
6.00	00600	MAINTENANCE & REPAIRS	301,128	1,729,554				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,991	17,972	270,637			8.00
9.00	00900	HOUSEKEEPING	118,671	18,139	24,668	724,404		9.00
10.00	01000	DIETARY	93,399	42,546	7,128	18,200	604,317	10.00
11.00	01100	CAFETERIA	77,395	13,093	1,846	5,601	0	11.00
13.00	01300	NURSING ADMINISTRATION	171,567	47,535	0	20,334	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,454	98,157	5,446	41,988	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	124,612	27,632	0	11,820	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	375,216	129,958	49,435	55,592	168,537	30.00
40.00	04000	SUBPROVIDER - IPF	198,756	55,736	20,050	23,842	51,531	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	78,631	3,322	1,823	1,421	0	43.00
44.00	04400	SKILLED NURSING FACILITY	29,182	30,467	6,120	13,033	16,405	44.00
45.00	04500	NURSING FACILITY	244,074	418,492	84,052	179,019	225,270	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	261,665	114,460	12,906	48,963	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,040	12,398	14,703	5,304	0	52.00
53.00	05300	ANESTHESIOLOGY	6,032	1,140	0	488	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303,622	86,161	7,466	36,857	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	340,891	35,276	5,958	15,090	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	62,357	31,760	2,383	13,586	0	65.00
66.00	06600	PHYSICAL THERAPY	105,645	40,252	4,905	17,219	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,839	14,789	0	6,326	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,969	9,368	0	4,007	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,294	1,779	0	761	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,542	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,829	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,309	27,660	0	11,832	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	56,914	24,741	0	10,583	0	75.01
76.97	07697	CARDIAC REHABILITATION	5,534	5,504	0	2,354	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,305,694	289,146	2,631	123,688	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	39,718	54,235	439	23,200	0	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	142,906	31,746	16,837	13,580	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	163,029	22,058	1,841	9,436	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,216,905	1,705,522	270,637	714,124	461,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	160,609	16,332	0	6,986	0	192.00
193.00	19300	NONPAID WORKERS	40,575	7,700	0	3,294	0	193.00
194.00	07950	EMERALD POINT	88,174	0	0	0	142,574	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,506,263	1,729,554	270,637	724,404	604,317	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	14.00	16.00	19.00	
		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 DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	465,066					11.00
13.00	01300	NURSING ADMINISTRATION	39,380	1,092,657				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,885	0	561,877			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,704	0	464	778,341		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,340	144,988	25,099	36,878	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	90,255	5,154	21,653	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,657	27,272	0	3,383	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,254	12,236	0	982	0	44.00
45.00	04500	NURSING FACILITY	85,888	168,039	11,336	13,484	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,774	72,788	53,832	56,843	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,295	6,481	0	8,052	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,006	16,974	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,213	57,084	8,871	190,173	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	25,035	70,700	182,855	151,775	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,406	35,134	4,071	16,121	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,108	28,225	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,431	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,099	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,035	0	0	13,392	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	185,130	15,983	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	28,569	3,329	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,373	20,821	0	63,218	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	7,991	22,567	268	9,070	0	75.01
76.97	07697	CARDIAC REHABILITATION	570	1,609	24	1,016	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	62,484	188,963	31,501	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	4,389	12,394	494	143	0	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	17,963	50,729	13,533	81,116	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	73,356	4,741	32,001	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	407,636	1,055,416	560,056	778,341	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,073	26,757	1,254	0	0	192.00
193.00	19300	NONPAID WORKERS	1,357	0	195	0	0	193.00
194.00	07950	EMERALD POINT	0	10,484	372	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	465,066	1,092,657	561,877	778,341	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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 DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,816,910	0	2,816,910		30.00
40.00	04000	SUBPROVIDER - IPF	1,409,793	0	1,409,793		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	498,503	0	498,503		43.00
44.00	04400	SKILLED NURSING FACILITY	253,106	0	253,106		44.00
45.00	04500	NURSING FACILITY	2,587,441	0	2,587,441		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,888,462	0	1,888,462		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181,565	0	181,565		52.00
53.00	05300	ANESTHESIOLOGY	54,253	0	54,253		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,150,706	0	2,150,706		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	2,444,625	0	2,444,625		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	469,615	0	469,615		65.00
66.00	06600	PHYSICAL THERAPY	700,492	0	700,492		66.00
67.00	06700	OCCUPATIONAL THERAPY	248,877	0	248,877		67.00
68.00	06800	SPEECH PATHOLOGY	155,141	0	155,141		68.00
69.00	06900	ELECTROCARDIOLOGY	165,243	0	165,243		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	715,405	0	715,405		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	111,324	0	111,324		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,746,627	0	1,746,627		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	402,109	0	402,109		75.01
76.97	07697	CARDIAC REHABILITATION	42,860	0	42,860		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8,197,797	0	8,197,797		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0		88.05
90.00	09000	CLINIC	323,420	0	323,420		90.00
90.01	09001	WELLNESS LINK	0	0	0		90.01
91.00	09100	EMERGENCY	1,046,298	0	1,046,298		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,079,805	0	1,079,805		95.00
99.10	09910	CORF	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,690,377	0	29,690,377		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,029,872	0	1,029,872		192.00
193.00	19300	NONPAID WORKERS	245,590	0	245,590		193.00
194.00	07950	EMERALD POINT	659,865	0	659,865		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118-201)	31,625,704	0	31,625,704		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		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 DEPARTMENT	0	1,548	1,668	3,216	3,216	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	75,505	81,358	156,863	431	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	86,737	93,460	180,197	60	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,401	16,595	31,996	24	8.00
9.00	00900	HOUSEKEEPING	0	15,544	16,749	32,293	76	9.00
10.00	01000	DIETARY	0	36,460	39,286	75,746	42	10.00
11.00	01100	CAFETERIA	0	11,220	12,090	23,310	45	11.00
13.00	01300	NURSING ADMINISTRATION	0	40,736	43,894	84,630	116	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	84,117	90,637	174,754	24	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,679	25,515	49,194	89	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	111,370	120,002	231,372	223	30.00
40.00	04000	SUBPROVIDER - IPF	0	47,764	51,466	99,230	140	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	2,847	3,067	5,914	55	43.00
44.00	04400	SKILLED NURSING FACILITY	0	26,109	28,133	54,242	12	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	171	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	98,089	105,692	203,781	140	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,625	11,448	22,073	13	52.00
53.00	05300	ANESTHESIOLOGY	0	977	1,052	2,029	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,838	79,561	153,399	117	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	30,231	32,574	62,805	116	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	27,217	29,327	56,544	39	65.00
66.00	06600	PHYSICAL THERAPY	0	34,495	37,169	71,664	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,674	13,656	26,330	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,028	8,650	16,678	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,525	1,643	3,168	19	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	23,703	25,541	49,244	87	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	21,202	22,845	44,047	27	75.01
76.97	07697	CARDIAC REHABILITATION	0	4,717	5,082	9,799	3	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	247,789	266,997	514,786	813	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	46,478	50,080	96,558	15	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	27,205	29,314	56,519	99	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	18,903	20,368	39,271	115	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,266,733	1,364,919	2,631,652	3,111	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,996	15,080	29,076	86	192.00
193.00	19300	NONPAID WORKERS	0	6,599	7,110	13,709	6	193.00
194.00	07950	EMERALD POINT	0	0	0	0	13	194.00
200.00		Cross Foot Adjustments				0		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		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	1,287,328	1,387,109	2,674,437	3,216	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		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 DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	157,294					5.00
6.00	00600	MAINTENANCE & REPAIRS	8,602	188,859				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,257	1,962	35,239			8.00
9.00	00900	HOUSEKEEPING	3,390	1,981	3,212	40,952		9.00
10.00	01000	DIETARY	2,668	4,646	928	1,029	85,059	10.00
11.00	01100	CAFETERIA	2,211	1,430	240	317	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,901	5,191	0	1,150	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,041	10,718	709	2,374	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,560	3,017	0	668	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,718	14,191	6,437	3,143	23,722	30.00
40.00	04000	SUBPROVIDER - IPF	5,678	6,086	2,611	1,348	7,253	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,246	363	237	80	0	43.00
44.00	04400	SKILLED NURSING FACILITY	834	3,327	797	737	2,309	44.00
45.00	04500	NURSING FACILITY	6,972	45,698	10,945	10,118	31,707	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,475	12,499	1,680	2,768	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	658	1,354	1,914	300	0	52.00
53.00	05300	ANESTHESIOLOGY	172	124	0	28	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,673	9,408	972	2,084	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	9,738	3,852	776	853	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,781	3,468	310	768	0	65.00
66.00	06600	PHYSICAL THERAPY	3,018	4,395	639	973	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,081	1,615	0	358	0	67.00
68.00	06800	SPEECH PATHOLOGY	685	1,023	0	227	0	68.00
69.00	06900	ELECTROCARDIOLOGY	723	194	0	43	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,558	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	395	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,036	3,020	0	669	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	1,626	2,702	0	598	0	75.01
76.97	07697	CARDIAC REHABILITATION	158	601	0	133	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	37,299	31,573	343	6,992	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	1,135	5,922	57	1,312	0	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,082	3,466	2,192	768	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,657	2,409	240	533	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	149,028	186,235	35,239	40,371	64,991	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,588	1,783	0	395	0	192.00
193.00	19300	NONPAID WORKERS	1,159	841	0	186	0	193.00
194.00	07950	EMERALD POINT	2,519	0	0	0	20,068	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	157,294	188,859	35,239	40,952	85,059	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	14.00	16.00	19.00	
		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 DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	27,553					11.00
13.00	01300	NURSING ADMINISTRATION	2,333	98,321				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	349	0	190,969			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,345	0	158	58,031		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,042	13,047	8,531	2,751		30.00
40.00	04000	SUBPROVIDER - IPF	0	8,121	1,752	1,615		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	572	2,454	0	252		43.00
44.00	04400	SKILLED NURSING FACILITY	371	1,101	0	73		44.00
45.00	04500	NURSING FACILITY	5,088	15,121	3,853	1,006		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,527	6,550	18,296	4,240		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136	583	0	601		52.00
53.00	05300	ANESTHESIOLOGY	0	0	342	1,266		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,198	5,137	3,015	14,156		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	1,483	6,362	62,148	11,322		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	498	3,161	1,384	1,203		65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,056	2,105		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	778		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	306		68.00
69.00	06900	ELECTROCARDIOLOGY	239	0	0	999		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	62,921	1,192		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	9,710	248		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	437	1,874	0	4,716		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	473	2,031	91	677		75.01
76.97	07697	CARDIAC REHABILITATION	34	145	8	76		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,702	17,002	10,706	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0		88.05
90.00	09000	CLINIC	260	1,115	168	11		90.00
90.01	09001	WELLNESS LINK	0	0	0	0		90.01
91.00	09100	EMERGENCY	1,064	4,565	4,600	6,051		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,601	1,612	2,387		95.00
99.10	09910	CORF	0	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,151	94,970	190,351	58,031	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,322	2,408	426	0		192.00
193.00	19300	NONPAID WORKERS	80	0	66	0		193.00
194.00	07950	EMERALD POINT	0	943	126	0		194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	27,553	98,321	190,969	58,031	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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 DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	317,177	0	317,177		30.00
40.00	04000	SUBPROVIDER - IPF	133,834	0	133,834		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	12,173	0	12,173		43.00
44.00	04400	SKILLED NURSING FACILITY	63,803	0	63,803		44.00
45.00	04500	NURSING FACILITY	130,679	0	130,679		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	258,956	0	258,956		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,632	0	27,632		52.00
53.00	05300	ANESTHESIOLOGY	3,961	0	3,961		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,159	0	198,159		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	159,455	0	159,455		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	69,156	0	69,156		65.00
66.00	06600	PHYSICAL THERAPY	83,850	0	83,850		66.00
67.00	06700	OCCUPATIONAL THERAPY	30,162	0	30,162		67.00
68.00	06800	SPEECH PATHOLOGY	18,919	0	18,919		68.00
69.00	06900	ELECTROCARDIOLOGY	5,385	0	5,385		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,671	0	66,671		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,353	0	10,353		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,083	0	68,083		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	52,272	0	52,272		75.01
76.97	07697	CARDIAC REHABILITATION	10,957	0	10,957		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	623,216	0	623,216		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0		88.05
90.00	09000	CLINIC	106,553	0	106,553		90.00
90.01	09001	WELLNESS LINK	0	0	0		90.01
91.00	09100	EMERGENCY	83,406	0	83,406		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	57,825	0	57,825		95.00
99.10	09910	CORF	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,592,637	0	2,592,637		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,084	0	42,084		192.00
193.00	19300	NONPAID WORKERS	16,047	0	16,047		193.00
194.00	07950	EMERALD POINT	23,669	0	23,669		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118-201)	2,674,437	0	2,674,437		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	108,077					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		108,077				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	130	130	15,538,859			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,339	6,339	2,081,790	-5,506,263	26,119,441	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,282	7,282	290,622	0	1,428,426	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,293	1,293	117,462	0	208,674	8.00
9.00	00900	HOUSEKEEPING	1,305	1,305	368,548	0	562,926	9.00
10.00	01000	DIETARY	3,061	3,061	203,222	0	443,044	10.00
11.00	01100	CAFETERIA	942	942	218,813	0	367,131	11.00
13.00	01300	NURSING ADMINISTRATION	3,420	3,420	561,319	0	813,841	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,062	7,062	117,480	0	338,947	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,988	1,988	429,751	0	591,109	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,350	9,350	1,077,631	0	1,779,867	30.00
40.00	04000	SUBPROVIDER - IPF	4,010	4,010	674,885	0	942,816	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	239	239	266,480	0	372,994	43.00
44.00	04400	SKILLED NURSING FACILITY	2,192	2,192	60,015	0	138,427	44.00
45.00	04500	NURSING FACILITY	0	0	825,570	0	1,157,787	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,235	8,235	678,516	0	1,241,231	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	892	892	63,316	0	109,292	52.00
53.00	05300	ANESTHESIOLOGY	82	82	0	0	28,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,199	6,199	566,207	0	1,440,259	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,538	2,538	562,720	0	1,617,045	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,285	2,285	187,779	0	295,797	65.00
66.00	06600	PHYSICAL THERAPY	2,896	2,896	0	0	501,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,064	1,064	0	0	179,492	67.00
68.00	06800	SPEECH PATHOLOGY	674	674	0	0	113,698	68.00
69.00	06900	ELECTROCARDIOLOGY	128	128	91,227	0	119,982	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	424,750	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	65,597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,990	1,990	421,599	0	1,334,414	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	1,780	1,780	132,317	0	269,975	75.01
76.97	07697	CARDIAC REHABILITATION	396	396	12,883	0	26,249	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,803	20,803	3,910,665	0	6,193,690	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	3,902	3,902	73,003	0	188,408	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,284	2,284	479,107	0	677,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,587	1,587	556,417	0	773,343	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	106,348	106,348	15,029,344	-5,506,263	24,746,850	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,175	1,175	417,258	0	761,861	192.00
193.00	19300	NONPAID WORKERS	554	554	31,330	0	192,469	193.00
194.00	07950	EMERALD POINT	0	0	60,927	0	418,261	194.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
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)	1,287,328	1,387,109	3,348,265		5,506,263	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.911211	12.834451	0.215477		0.210811	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,216		157,294	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000207		0.006022	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			6.00	8.00	9.00	10.00	11.00	
		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 DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	124,435					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,293	342,168				8.00
9.00	00900	HOUSEKEEPING	1,305	31,188	121,837			9.00
10.00	01000	DIETARY	3,061	9,012	3,061	67,267		10.00
11.00	01100	CAFETERIA	942	2,334	942	0	479,279	11.00
13.00	01300	NURSING ADMINISTRATION	3,420	0	3,420	0	40,583	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,062	6,885	7,062	0	6,065	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,988	0	1,988	0	23,398	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,350	62,501	9,350	18,760	52,909	30.00
40.00	04000	SUBPROVIDER - IPF	4,010	25,349	4,010	5,736	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	239	2,305	239	0	9,952	43.00
44.00	04400	SKILLED NURSING FACILITY	2,192	7,738	2,192	1,826	6,445	44.00
45.00	04500	NURSING FACILITY	30,109	106,268	30,109	25,075	88,514	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,235	16,317	8,235	0	26,562	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	892	18,589	892	0	2,365	52.00
53.00	05300	ANESTHESIOLOGY	82	0	82	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,199	9,439	6,199	0	20,831	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,538	7,533	2,538	0	25,800	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,285	3,013	2,285	0	8,663	65.00
66.00	06600	PHYSICAL THERAPY	2,896	6,201	2,896	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,064	0	1,064	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	674	0	674	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	128	0	128	0	4,158	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	1,990	0	1,990	0	7,598	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	1,780	0	1,780	0	8,235	75.01
76.97	07697	CARDIAC REHABILITATION	396	0	396	0	587	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,803	3,327	20,803	0	64,394	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	3,902	555	3,902	0	4,523	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,284	21,287	2,284	0	18,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,587	2,327	1,587	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	122,706	342,168	120,108	51,397	420,094	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,175	0	1,175	0	57,787	192.00
193.00	19300	NONPAID WORKERS	554	0	554	0	1,398	193.00
194.00	07950	EMERALD POINT	0	0	0	15,870	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		6.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,729,554	270,637	724,404	604,317	465,066	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.899257	0.790948	5.945682	8.983855	0.970345	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	188,859	35,239	40,952	85,059	27,553	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.517732	0.102987	0.336121	1.264498	0.057488	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	14.00	16.00	19.00		
		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 DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	398,733					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,290,140				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,065	62,633,840			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,909	57,630	2,967,565			30.00
40.00	04000	SUBPROVIDER - IPF	32,936	11,835	1,742,452			40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0			41.00
42.00	04200	SUBPROVIDER	0	0	0			42.00
43.00	04300	NURSERY	9,952	0	272,266			43.00
44.00	04400	SKILLED NURSING FACILITY	4,465	0	79,012			44.00
45.00	04500	NURSING FACILITY	61,321	26,029	1,085,082			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,562	123,606	4,574,192	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,365	0	647,951	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,311	1,365,888	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,831	20,370	15,303,979	0		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	25,800	419,858	12,213,293	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	12,821	9,347	1,297,217	0		65.00
66.00	06600	PHYSICAL THERAPY	0	7,136	2,271,272	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	839,372	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	329,842	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,077,653	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	425,077	1,286,154	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	65,597	267,924	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,598	0	5,087,114	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	8,235	616	729,830	0		75.01
76.97	07697	CARDIAC REHABILITATION	587	56	81,788	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	68,957	72,330	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0		88.05
90.00	09000	CLINIC	4,523	1,134	11,493	0		90.00
90.01	09001	WELLNESS LINK	0	0	0	0		90.01
91.00	09100	EMERGENCY	18,512	31,074	6,527,410	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	26,769	10,887	2,575,091	0		95.00
99.10	09910	CORF	0	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	385,143	1,285,958	62,633,840	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,764	2,880	0	0		192.00
193.00	19300	NONPAID WORKERS	0	448	0	0		193.00
194.00	07950	EMERALD POINT	3,826	854	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/5/2014 7:51 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	14.00	16.00	19.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	1,092,657	561,877	778,341	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.740322	0.435516	0.012427	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,321	190,969	58,031	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.246584	0.148022	0.000927	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,816,910		2,816,910	0	2,816,910	30.00
40.00	04000	SUBPROVIDER - IPF	1,409,793		1,409,793	0	1,409,793	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	498,503		498,503	0	498,503	43.00
44.00	04400	SKILLED NURSING FACILITY	253,106		253,106	0	253,106	44.00
45.00	04500	NURSING FACILITY	2,587,441		2,587,441	0	2,587,441	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,888,462		1,888,462	0	1,888,462	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	181,565		181,565	0	181,565	52.00
53.00	05300	ANESTHESIOLOGY	54,253		54,253	0	54,253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,150,706		2,150,706	0	2,150,706	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,444,625		2,444,625	0	2,444,625	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	469,615	0	469,615	0	469,615	65.00
66.00	06600	PHYSICAL THERAPY	700,492	0	700,492	0	700,492	66.00
67.00	06700	OCCUPATIONAL THERAPY	248,877	0	248,877	0	248,877	67.00
68.00	06800	SPEECH PATHOLOGY	155,141	0	155,141	0	155,141	68.00
69.00	06900	ELECTROCARDIOLOGY	165,243		165,243	0	165,243	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	715,405		715,405	0	715,405	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	111,324		111,324	0	111,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,746,627		1,746,627	0	1,746,627	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	402,109		402,109	0	402,109	75.01
76.97	07697	CARDIAC REHABILITATION	42,860		42,860	0	42,860	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,197,797		8,197,797	0	8,197,797	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0		0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0		0	0	0	88.05
90.00	09000	CLINIC	323,420		323,420	0	323,420	90.00
90.01	09001	WELLNESS LINK	0		0	0	0	90.01
91.00	09100	EMERGENCY	1,046,298		1,046,298	0	1,046,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	200,338		200,338		200,338	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,079,805		1,079,805	0	1,079,805	95.00
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,890,715	0	29,890,715	0	29,890,715	200.00
201.00		Less Observation Beds	200,338		200,338		200,338	201.00
202.00		Total (see instructions)	29,690,377	0	29,690,377	0	29,690,377	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,748,078		2,748,078			30.00
40.00	04000	SUBPROVIDER - IPF	1,742,452		1,742,452			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	272,266		272,266			43.00
44.00	04400	SKILLED NURSING FACILITY	79,012		79,012			44.00
45.00	04500	NURSING FACILITY	1,085,082		1,085,082			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	525,099	4,049,093	4,574,192	0.412851	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	400,204	247,747	647,951	0.280214	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	463,495	902,393	1,365,888	0.039720	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,041,340	14,262,639	15,303,979	0.140532	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,072,432	10,140,861	12,213,293	0.200161	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	380,377	916,840	1,297,217	0.362017	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	435,846	1,835,426	2,271,272	0.308414	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	513,713	325,659	839,372	0.296504	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	234,901	94,665	329,566	0.470743	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	139,804	937,849	1,077,653	0.153336	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	430,070	856,084	1,286,154	0.556236	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,584	262,340	267,924	0.415506	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,281,975	3,805,139	5,087,114	0.343343	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	6,680	723,150	729,830	0.550963	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	127	81,661	81,788	0.524038	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,705,745	4,705,745			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0			88.05
90.00	09000	CLINIC	0	11,493	11,493	28.140607	0.000000	90.00
90.01	09001	WELLNESS LINK	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	569,106	5,958,304	6,527,410	0.160293	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	38,786	180,701	219,487	0.912756	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	211,095	2,363,996	2,575,091	0.419327	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,677,524	52,661,785	67,339,309			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,677,524	52,661,785	67,339,309			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.412851	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.280214	52.00
53.00	05300	ANESTHESIOLOGY	0.039720	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140532	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.200161	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.362017	65.00
66.00	06600	PHYSICAL THERAPY	0.308414	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.296504	67.00
68.00	06800	SPEECH PATHOLOGY	0.470743	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153336	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415506	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343343	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.550963	75.01
76.97	07697	CARDIAC REHABILITATION	0.524038	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.03	08803	RURAL HEALTH CLINIC IV		88.03
88.04	08804	RURAL HEALTH CLINIC V		88.04
88.05	08805	RURAL HEALTH CLINIC VI		88.05
90.00	09000	CLINIC	28.140607	90.00
90.01	09001	WELLNESS LINK	0.000000	90.01
91.00	09100	EMERGENCY	0.160293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912756	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.419327	95.00
99.10	09910	CORF		99.10
		SPECIAL PURPOSE COST CENTERS		
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part I | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	317,177	0	317,177	2,545	124.63	30.00
40.00	SUBPROVIDER - IPF	133,834	0	133,834	1,899	70.48	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	12,173		12,173	443	27.48	43.00
44.00	SKILLED NURSING FACILITY	63,803		63,803	607	105.11	44.00
45.00	NURSING FACILITY	130,679		130,679	8,336	15.68	45.00
200.00	Total (lines 30-199)	657,666		657,666	13,830		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,276	159,028	30.00
40.00	SUBPROVIDER - IPF	1,767	124,538	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	607	63,802	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	3,650	347,368	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

		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	258,956	4,574,192	0.056612	169,418	9,591	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,632	647,951	0.042645	2,279	97	52.00
53.00	05300	ANESTHESIOLOGY	3,961	1,365,888	0.002900	24,024	70	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,159	15,303,979	0.012948	818,510	10,598	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	159,455	12,213,293	0.013056	1,225,445	15,999	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	69,156	1,297,217	0.053311	212,602	11,334	65.00
66.00	06600	PHYSICAL THERAPY	83,850	2,271,272	0.036918	49,522	1,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,162	839,372	0.035934	74,340	2,671	67.00
68.00	06800	SPEECH PATHOLOGY	18,919	329,566	0.057406	48,844	2,804	68.00
69.00	06900	ELECTROCARDIOLOGY	5,385	1,077,653	0.004997	91,859	459	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,671	1,286,154	0.051837	174,829	9,063	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,353	267,924	0.038642	5,584	216	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,083	5,087,114	0.013383	441,885	5,914	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	52,272	729,830	0.071622	468	34	75.01
76.97	07697	CARDIAC REHABILITATION	10,957	81,788	0.133968	127	17	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	623,216	4,705,745	0.132437	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0.000000	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0.000000	0	0	88.05
90.00	09000	CLINIC	106,553	11,493	9.271122	0	0	90.00
90.01	09001	WELLNESS LINK	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	83,406	6,527,410	0.012778	462,024	5,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	22,557	219,487	0.102771	25,036	2,573	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,899,703	58,837,328		3,826,796	79,172	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part III Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,545	0.00	1,276	0		30.00
40.00	04000	SUBPROVIDER - IPF	1,899	0.00	1,767	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	443	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	607	0.00	607	0		44.00
45.00	04500	NURSING FACILITY	8,336	0.00	0	0		45.00
200.00		Total (lines 30-199)	13,830		3,650	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | 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
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		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: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | 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	4,574,192	0.000000	0.000000	169,418	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	647,951	0.000000	0.000000	2,279	52.00
53.00	05300	ANESTHESIOLOGY	0	1,365,888	0.000000	0.000000	24,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,303,979	0.000000	0.000000	818,510	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	12,213,293	0.000000	0.000000	1,225,445	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,297,217	0.000000	0.000000	212,602	65.00
66.00	06600	PHYSICAL THERAPY	0	2,271,272	0.000000	0.000000	49,522	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	839,372	0.000000	0.000000	74,340	67.00
68.00	06800	SPEECH PATHOLOGY	0	329,566	0.000000	0.000000	48,844	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,077,653	0.000000	0.000000	91,859	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,286,154	0.000000	0.000000	174,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	267,924	0.000000	0.000000	5,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,087,114	0.000000	0.000000	441,885	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	729,830	0.000000	0.000000	468	75.01
76.97	07697	CARDIAC REHABILITATION	0	81,788	0.000000	0.000000	127	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,705,745	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0.000000	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0.000000	0.000000	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0.000000	0.000000	0	88.05
90.00	09000	CLINIC	0	11,493	0.000000	0.000000	0	90.00
90.01	09001	WELLNESS LINK	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,527,410	0.000000	0.000000	462,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	219,487	0.000000	0.000000	25,036	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	58,837,328			3,826,796	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | 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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,421,120	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	117,585	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,329,141	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	166,495	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	397,263	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	235	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	523,956	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326,090	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	70,423	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,303,751	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	625,604	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	45,339	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0		88.05
90.00	09000	CLINIC	0	3,232	0		90.00
90.01	09001	WELLNESS LINK	0	0	0		90.01
91.00	09100	EMERGENCY	0	1,888,051	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	85,905	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	13,304,190	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.412851	1,421,120	0	0	586,711	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.280214	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.039720	117,585	0	0	4,670	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140532	5,329,141	0	0	748,915	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.200161	166,495	2,783	0	33,326	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.362017	397,263	0	0	143,816	65.00
66.00	06600	PHYSICAL THERAPY	0.308414	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.296504	235	0	0	70	67.00
68.00	06800	SPEECH PATHOLOGY	0.470743	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153336	523,956	0	0	80,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556236	326,090	0	0	181,383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415506	70,423	0	0	29,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343343	2,303,751	1,316	0	790,977	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.550963	625,604	0	0	344,685	75.01
76.97	07697	CARDIAC REHABILITATION	0.524038	45,339	0	0	23,759	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000				0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000				0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000				0	88.05
90.00	09000	CLINIC	28.140607	3,232	0	0	90,950	90.00
90.01	09001	WELLNESS LINK	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.160293	1,888,051	0	0	302,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912756	85,905	0	0	78,410	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.419327		0			95.00
200.00		Subtotal (see instructions)		13,304,190	4,099	0	3,439,915	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		13,304,190	4,099	0	3,439,915	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	557	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
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	452	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0		88.05
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WELLNESS LINK	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,009	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,009	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140137 | Component CCN: 14S137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Subprovider - IPF | PPS

		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	258,956	4,574,192	0.056612	1,699	96	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,632	647,951	0.042645	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,961	1,365,888	0.002900	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,159	15,303,979	0.012948	150,235	1,945	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	159,455	12,213,293	0.013056	376,780	4,919	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	69,156	1,297,217	0.053311	6,278	335	65.00
66.00	06600	PHYSICAL THERAPY	83,850	2,271,272	0.036918	34,392	1,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,162	839,372	0.035934	15,910	572	67.00
68.00	06800	SPEECH PATHOLOGY	18,919	329,566	0.057406	19,575	1,124	68.00
69.00	06900	ELECTROCARDIOLOGY	5,385	1,077,653	0.004997	41,435	207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,671	1,286,154	0.051837	4,146	215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,353	267,924	0.038642	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,083	5,087,114	0.013383	322,008	4,309	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	52,272	729,830	0.071622	6,212	445	75.01
76.97	07697	CARDIAC REHABILITATION	10,957	81,788	0.133968	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	623,216	4,705,745	0.132437	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0.000000	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0.000000	0	0	88.05
90.00	09000	CLINIC	106,553	11,493	9.271122	0	0	90.00
90.01	09001	WELLNESS LINK	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	83,406	6,527,410	0.012778	104,086	1,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	219,487	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,877,146	58,837,328		1,082,756	16,767	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140137 | Component CCN: 14S137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Subprovider - IPF | 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
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		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: 140137 | Component CCN: 14S137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Subprovider - IPF | 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	4,574,192	0.000000	0.000000	1,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	647,951	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,365,888	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,303,979	0.000000	0.000000	150,235	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	12,213,293	0.000000	0.000000	376,780	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,297,217	0.000000	0.000000	6,278	65.00
66.00	06600	PHYSICAL THERAPY	0	2,271,272	0.000000	0.000000	34,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	839,372	0.000000	0.000000	15,910	67.00
68.00	06800	SPEECH PATHOLOGY	0	329,566	0.000000	0.000000	19,575	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,077,653	0.000000	0.000000	41,435	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,286,154	0.000000	0.000000	4,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	267,924	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,087,114	0.000000	0.000000	322,008	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	729,830	0.000000	0.000000	6,212	75.01
76.97	07697	CARDIAC REHABILITATION	0	81,788	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,705,745	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0.000000	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0.000000	0.000000	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0.000000	0.000000	0	88.05
90.00	09000	CLINIC	0	11,493	0.000000	0.000000	0	90.00
90.01	09001	WELLNESS LINK	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,527,410	0.000000	0.000000	104,086	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	219,487	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	58,837,328			1,082,756	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140137 | Component CCN: 14S137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Subprovider - IPF | 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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0		88.05
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WELLNESS LINK	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140137 | Component CCN: 146022 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/5/2014 7:51 am

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
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		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: 140137 | Component CCN: 146022 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/5/2014 7:51 am

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	4,574,192	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	647,951	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,365,888	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,303,979	0.000000	0.000000	3,781	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	12,213,293	0.000000	0.000000	20,518	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,297,217	0.000000	0.000000	546	65.00
66.00	06600	PHYSICAL THERAPY	0	2,271,272	0.000000	0.000000	110,659	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	839,372	0.000000	0.000000	157,046	67.00
68.00	06800	SPEECH PATHOLOGY	0	329,566	0.000000	0.000000	76,081	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,077,653	0.000000	0.000000	186	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,286,154	0.000000	0.000000	117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	267,924	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,087,114	0.000000	0.000000	71,521	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	729,830	0.000000	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	81,788	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,705,745	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0.000000	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0.000000	0.000000	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0.000000	0.000000	0	88.05
90.00	09000	CLINIC	0	11,493	0.000000	0.000000	0	90.00
90.01	09001	WELLNESS LINK	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,527,410	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	219,487	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	58,837,328			440,455	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140137 | Component CCN: 146022 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/5/2014 7:51 am

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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0		88.05
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WELLNESS LINK	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | 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)	3,572	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,545	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)	2,364	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,001	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	26	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,276	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)	989	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	2,816,910	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)	2,816,910	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	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)	0.00	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)	2,816,910	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)	1,106.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,412,328	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)	1,412,328	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | 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)	0	0	0.00	0	0	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)	931,729	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,344,057	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)	159,028	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	79,172	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	238,200	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,105,857	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	181	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,106.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	200,338	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | 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	317,177	2,816,910	0.112597	200,338	22,557	90.00
91.00	Nursing School cost	0	2,816,910	0.000000	200,338	0	91.00
92.00	Allied health cost	0	2,816,910	0.000000	200,338	0	92.00
93.00	All other Medical Education	0	2,816,910	0.000000	200,338	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140137 Component CCN: 14S137	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/5/2014 7:51 am
	Title XVIII	Subprovider - IPF	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)	1,899	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,899	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)	1,899	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)	1,767	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	1,409,793	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)	1,409,793	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	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)	0.00	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)	1,409,793	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)	742.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,311,803	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)	1,311,803	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140137 | Component CCN: 14S137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Subprovider - IPF | 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)	0	0	0.00	0	0	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)	263,368	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,575,171	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)	124,538	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	16,767	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	141,305	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,433,866	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	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: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1

Component CCN: 14S137 | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Subprovider - IPF | 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	133,834	1,409,793	0.094932	0	0	90.00
91.00	Nursing School cost	0	1,409,793	0.000000	0	0	91.00
92.00	Allied health cost	0	1,409,793	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,409,793	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140137 Component CCN: 146022	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/5/2014 7:51 am
	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)	607	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	607	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)	607	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)	607	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	253,106	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)	253,106	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	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)	0.00	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)	253,106	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: 140137 | Component CCN: 146022 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/5/2014 7:51 am

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)	253,106	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	416.98	71.00
72.00	Program routine service cost (line 9 x line 71)	253,107	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)	253,107	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)	253,107	83.00
84.00	Program inpatient ancillary services (see instructions)	145,995	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)	399,102	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: 140137 Component CCN: 146022	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/5/2014 7:51 am
	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: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Hospital | 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		1,188,372		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.412851	169,418	69,944	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.280214	2,279	639	52.00
53.00	05300	ANESTHESIOLOGY	0.039720	24,024	954	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140532	818,510	115,027	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.200161	1,225,445	245,286	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.362017	212,602	76,966	65.00
66.00	06600	PHYSICAL THERAPY	0.308414	49,522	15,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.296504	74,340	22,042	67.00
68.00	06800	SPEECH PATHOLOGY	0.470743	48,844	22,993	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153336	91,859	14,085	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556236	174,829	97,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415506	5,584	2,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343343	441,885	151,718	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.550963	468	258	75.01
76.97	07697	CARDIAC REHABILITATION	0.524038	127	67	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	28.140607	0	0	90.00
90.01	09001	WELLNESS LINK	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.160293	462,024	74,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912756	25,036	22,852	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,826,796	931,729	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)		3,826,796		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140137 | Component CCN: 14S137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Subprovider - IPF | 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
40.00	04000	SUBPROVIDER - IPF		1,611,700		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.412851	1,699	701	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.280214	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.039720	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140532	150,235	21,113	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.200161	376,780	75,417	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.362017	6,278	2,273	65.00
66.00	06600	PHYSICAL THERAPY	0.308414	34,392	10,607	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.296504	15,910	4,717	67.00
68.00	06800	SPEECH PATHOLOGY	0.470743	19,575	9,215	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153336	41,435	6,353	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556236	4,146	2,306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415506	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343343	322,008	110,559	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.550963	6,212	3,423	75.01
76.97	07697	CARDIAC REHABILITATION	0.524038	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	28.140607	0	0	90.00
90.01	09001	WELLNESS LINK	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.160293	104,086	16,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912756	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,082,756	263,368	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)		1,082,756		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140137 | Component CCN: 14U137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Swing Beds - SNF | 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
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.412851	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.280214	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.039720	1,053	42	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140532	68,814	9,671	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.200161	266,999	53,443	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.362017	100,383	36,340	65.00
66.00	06600	PHYSICAL THERAPY	0.308414	227,024	70,017	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.296504	249,137	73,870	67.00
68.00	06800	SPEECH PATHOLOGY	0.470743	84,325	39,695	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153336	6,324	970	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556236	62,495	34,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415506	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343343	211,434	72,594	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.550963	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.524038	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	28.140607	0	0	90.00
90.01	09001	WELLNESS LINK	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.160293	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912756	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,277,988	391,404	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)		1,277,988		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140137 | Component CCN: 146022 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/5/2014 7:52 am

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
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.412851	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.280214	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.039720	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140532	3,781	531	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.200161	20,518	4,107	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.362017	546	198	65.00
66.00	06600	PHYSICAL THERAPY	0.308414	110,659	34,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.296504	157,046	46,565	67.00
68.00	06800	SPEECH PATHOLOGY	0.470743	76,081	35,815	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153336	186	29	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.556236	117	65	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415506	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343343	71,521	24,556	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.550963	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.524038	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	28.140607	0	0	90.00
90.01	09001	WELLNESS LINK	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.160293	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.912756	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		440,455	145,995	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)		440,455		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140137	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/5/2014 7:51 am
	Title XVIII	Hospital	PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		1,699,827		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		487,823		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0		1.03
2.00	Outlier payments for discharges. (see instructions)		0		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		28.69		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.52		30.00
31.00	Percentage of Medicaid patient days (see instructions)		34.95		31.00
32.00	Sum of lines 30 and 31		38.47		32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00		33.00
34.00	Disproportionate share adjustment (see instructions)		218,614		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			244,847	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			61,715	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		61,715		36.00
	Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		2,467,979		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		2,467,979		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		173,166		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		2,641,145		59.00
60.00	Primary payer payments		1,466		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,639,679		61.00
62.00	Deductibles billed to program beneficiaries		329,124		62.00
63.00	Coinsurance billed to program beneficiaries		888		63.00
64.00	Allowable bad debts (see instructions)		72,884		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		47,375		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		72,884		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,357,042		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	LOW VOLUME ADJUSTMENT AFTER 9/30		133,172		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-10,908		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-683		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2013	423,184		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,901,807		71.00
71.01	Sequestration adjustment (see instructions)		43,817		71.01
72.00	Interim payments		2,975,474		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-117,484		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		75.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	1,699,827	0	1,699,827	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	487,823	0	0	487,823	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	218,614	0	160,075	58,539	11.00
11.01	Uncompensated care payments	36.00	61,715	61,715	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,467,979	61,715	1,859,902	546,362	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	2,467,979	61,715	1,859,902	546,362	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	173,166	0	129,875	43,291	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			61,715	1,989,777	589,653	19.00
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	173,166	0	129,875	43,291	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	173,166	0	129,875	43,291	26.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	
27.00	Low volume adjustment factor				0.212679	0.000000	27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			423,184		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Hospital | PPS

		Total (Col 2 through 4)		
		5.00		
1.00	DRG amounts other than outlier payments	0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1,699,827		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	487,823		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	0		1.03
2.00	Outlier payments for discharges (see instructions)	0		2.00
2.01	Outlier payments for discharges for Model 4 BPCI	0		2.01
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
	Indirect Medical Education Adjustment			
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
	Disproportionate Share Adjustment			
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	218,614		11.00
11.01	Uncompensated care payments	61,715		11.01
	Additional payment for high percentage of ESRD beneficiary discharges			
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	2,467,979		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	2,467,979		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	173,166		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	2,641,145		19.00
		5.00		
20.00	Capital DRG other than outlier	173,166		20.00
20.01	Model 4 BPCI Capital DRG other than outlier	0		20.01
21.00	Capital DRG outlier payments	0		21.00
21.01	Model 4 BPCI Capital DRG outlier payments	0		21.01
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	173,166		26.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 140137	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/5/2014 7:52 am
	Title XVIII	Hospital	PPS

		5.00	
27.00	Low volume adjustment factor		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	423,184	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140137	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/5/2014 7:51 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,009	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,439,915	2.00
3.00	PPS payments	3,090,663	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)	1,009	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,099	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)	4,099	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	4,099	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,090	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)	1,009	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)	3,090,663	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	739,686	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,351,986	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,351,986	30.00
31.00	Primary payer payments	1,627	31.00
32.00	Subtotal (line 30 minus line 31)	2,350,359	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)	151,736	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	98,628	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	151,736	36.00
37.00	Subtotal (see instructions)	2,448,987	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-41	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,448,946	40.00
40.01	Sequestration adjustment (see instructions)	36,979	40.01
41.00	Interim payments	2,402,826	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	9,141	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,879,874		2,402,826	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	09/25/2013	403,000	09/25/2013	0	3.01
3.02		09/25/2013	26,200		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	03/24/2014	333,600		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)		95,600		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)		2,975,474		2,402,826	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		9,141	6.01
6.02	SETTLEMENT TO PROGRAM		117,484		0	6.02
7.00	Total Medicare program liability (see instructions)		2,857,990		2,411,967	7.00

			Contractor Number	NPR 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: 140137 | Component CCN: 14S137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Subprovider - IPF | PPS

		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		1,298,816		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		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)		1,298,816		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,298,816		0	7.00

			Contractor Number	NPR 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: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/5/2014 7:51 am

Component CCN: 14U137 | Title XVIII | Swing Beds - SNF | PPS

		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		404,746		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		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)		404,746		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		1		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		404,747		0	7.00

			Contractor Number	NPR 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: 140137 | Component CCN: 146022 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Skilled Nursing Facility | PPS

		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		210,052		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		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)		210,052		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		29,386		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		239,438		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140137	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/5/2014 7:51 am
	Title XVIII	Hospital	PPS

		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	921	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,276	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	24	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,364	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	67,339,309	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	939,026	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	557,700	8.00
9.00	Sequestration adjustment amount (see instructions)	11,154	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	546,546	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	547,918	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-1,372	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 140137 | Component CCN: 14U137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-2 | Date/Time Prepared: 5/5/2014 7:51 am

Title XVIII | Swing Beds - SNF | PPS

		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)	426,848	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 6 and 7, line 202 for Part B) (For CAH, see instructions)			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	989	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)	426,848	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	426,848	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)	426,848	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,836	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)	411,012	0	15.00
16.00	SEQUESTRATION ADJUSTMENT	-60	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	410,952	0	19.00
19.01	Sequestration adjustment (see instructions)	6,205	0	19.01
20.00	Interim payments	404,746	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	1	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140137 Component CCN: 14S137	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part II Date/Time Prepared: 5/5/2014 7:51 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,471,442	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	5.202740	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,471,442	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,471,442	16.00
17.00	Primary payer payments	1,741	17.00
18.00	Subtotal (line 16 less line 17).	1,469,701	18.00
19.00	Deductibles	143,264	19.00
20.00	Subtotal (line 18 minus line 19)	1,326,437	20.00
21.00	Coinsurance	8,288	21.00
22.00	Subtotal (line 20 minus line 21)	1,318,149	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,318,149	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	SEQUESTRATION ADJ	580	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,318,729	31.00
31.01	Sequestration adjustment (see instructions)	19,913	31.01
32.00	Interim payments	1,298,816	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140137 Component CCN: 146022	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VI Date/Time Prepared: 5/5/2014 7:51 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	273,315	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)	273,315	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	62,456	7.00
8.00	Allowable bad debts (see instructions)	36,648	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	36,648	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	32,250	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)	243,109	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	243,109	15.00
15.01	Sequestration adjustment (see instructions)	3,671	15.01
16.00	Interim payments	210,052	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	29,386	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G | Date/Time Prepared: 5/5/2014 7:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,743,041	0	0	0	1.00
2.00	Temporary investments	531,338	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,703,975	0	0	0	4.00
5.00	Other receivable	730,266	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	484,612	0	0	0	7.00
8.00	Prepaid expenses	329,071	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,522,303	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	1,197,527	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	30,925,486	0	0	0	15.00
16.00	Accumulated depreciation	-23,233,949	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	9,938,796	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	40,171	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,868,031	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,975,273	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	128,021	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,103,294	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,493,628	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,409,913	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,438,636	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	524,996	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,707,860	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,081,405	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,536,314	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,921,281	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	10,457,595	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	15,539,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,954,628				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)	13,954,628	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,493,628	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-1 | Date/Time Prepared: 5/5/2014 7:51 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,327,568		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,688,259				2.00
3.00	Total (sum of line 1 and line 2)		13,639,309		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFER TO AFFILIATES	315,319		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		315,319		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,954,628		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		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)		13,954,628		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/5/2014 7:51 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,700,952		2,700,952	1.00
2.00	SUBPROVIDER - IPF	1,742,452		1,742,452	2.00
3.00	SUBPROVIDER - IRF	450,722		450,722	3.00
4.00	SUBPROVIDER	0		0	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	79,012		79,012	7.00
8.00	NURSING FACILITY	1,085,082		1,085,082	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,058,220		6,058,220	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,058,220		6,058,220	17.00
18.00	Ancillary services	8,816,688	47,159,700	55,976,388	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	6,915,801	6,915,801	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
20.02	RURAL HEALTH CLINIC III	0	0	0	20.02
20.03	RURAL HEALTH CLINIC IV	0	0	0	20.03
20.04	RURAL HEALTH CLINIC V	0	0	0	20.04
20.05	RURAL HEALTH CLINIC VI	0	0	0	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	2,376,337	2,376,337	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	473,494	473,494	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,874,908	56,925,332	71,800,240	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,954,578		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	ALLOWANCE FOR BAD DEBTS	2,336,388			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)		2,336,388		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)		38,290,966		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140137	Period: From 01/01/2013 To 12/31/2013	Worksheet G-3 Date/Time Prepared: 5/5/2014 7:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,800,240	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,671,790	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,128,450	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,290,966	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,162,516	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	159,146	6.00
7.00	Income from investments	146,695	7.00
8.00	Revenues from telephone and other miscellaneous communication services	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	130,065	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	277,991	17.00
18.00	Revenue from sale of medical records and abstracts	17,049	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	337,315	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	500,277	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	1,905,719	24.00
25.00	Total other income (sum of lines 6-24)	3,474,257	25.00
26.00	Total (line 5 plus line 25)	-1,688,259	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,688,259	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet L Parts I-III Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	173,166	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	6.48	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	173,166	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 140137 Component CCN: 143491 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/5/2014 7:52 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,225,005	0	2,225,005	0	2,225,005	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	676,102	0	676,102	0	676,102	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	736,963	0	736,963	0	736,963	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	91,976	0	91,976	0	91,976	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)	3,730,046	0	3,730,046	0	3,730,046	10.00
11.00	Physician Services Under Agreement	0	241,752	241,752	0	241,752	11.00
12.00	Physician Supervision Under Agreement	0	1,326	1,326	0	1,326	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	243,078	243,078	0	243,078	14.00
15.00	Medical Supplies	0	207,182	207,182	0	207,182	15.00
16.00	Transportation (Health Care Staff)	0	7,016	7,016	0	7,016	16.00
17.00	Depreciation-Medical Equipment	0	3,737	3,737	0	3,737	17.00
18.00	Professional Liability Insurance	0	290,813	290,813	0	290,813	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	508,748	508,748	0	508,748	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,730,046	751,826	4,481,872	0	4,481,872	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	20,435	20,435	0	20,435	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	20,435	20,435	0	20,435	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	544,190	154,735	698,925	0	698,925	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	544,190	154,735	698,925	0	698,925	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,274,236	926,996	5,201,232	0	5,201,232	32.00

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

Provider CCN: 140137 Component CCN: 143491 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/5/2014 7:52 am

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	-283,277	1,941,728		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	676,102		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	-80,279	656,684		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	91,976		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)	-363,556	3,366,490		10.00
11.00	Physician Services Under Agreement	0	241,752		11.00
12.00	Physician Supervision Under Agreement	0	1,326		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	243,078		14.00
15.00	Medical Supplies	0	207,182		15.00
16.00	Transportation (Health Care Staff)	0	7,016		16.00
17.00	Depreciation-Medical Equipment	0	3,737		17.00
18.00	Professional Liability Insurance	0	290,813		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	508,748		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-363,556	4,118,316		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	20,435		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	20,435		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-1,430	697,495		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,430	697,495		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-364,986	4,836,246		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140137 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2

Component CCN: 143491 | Date/Time Prepared: 5/5/2014 7:52 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	5.45	18,377	4,200	22,890		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.42	14,391	2,100	9,282		3.00
4.00	Subtotal (sum of lines 1-3)	9.87	32,768		32,172	32,768	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	1.40	1,512			1,512	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)	11.27	34,280			34,280	8.00
9.00	Physician Services Under Agreements		957			957	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)					4,118,316	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					20,435	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,138,751	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.995063	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					697,495	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,361,551	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,059,046	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					4,059,046	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					4,039,006	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					8,157,322	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3 Date/Time Prepared: 5/5/2014 7:52 am
	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)		8,157,322	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		21,146	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		8,136,176	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		34,280	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		957	5.00
6.00	Total adjusted visits (line 4 plus line 5)		35,237	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		230.90	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. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	230.90	230.90	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	9,061	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,092,185	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	831	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	191,878	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	155,901	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) *		2,248,086	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,539,813	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		35,275	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		51,501	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.)		1,646,574	16.04
16.05	Total program cost (see instructions)		1,698,075	16.05
17.00	Primary payer amounts		5,198	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		138,368	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		295,841	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,692,877	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,072	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,712,949	22.00
23.00	Allowable bad debts (see instructions)		95,039	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		83,634	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		95,039	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		1,796,583	26.00
26.01	Sequestration adjustment (see instructions)		27,128	26.01
27.00	Interim payments		1,458,354	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		311,101	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: 140137 | Component CCN: 143491 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-4 | Date/Time Prepared: 5/5/2014 7:52 am

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	3,366,490	3,366,490	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.002000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	6,733	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,049	2,867	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,049	9,600	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	4,118,316	4,118,316	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	4,059,046	4,059,046	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000255	0.002331	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,035	9,462	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,084	19,062	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	17	390	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	122.59	48.88	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	17	368	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,084	17,988	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)		21,146	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)		20,072	16.00

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

Provider CCN: 140137 Component CCN: 143491 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 5/5/2014 7:52 am

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,425,654	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		06/28/2013	32,700	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)		32,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,458,354	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		311,101	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,769,455	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00