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: 140294	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 6/1/2014 6:51 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 6/1/2014 Time: 6:51 pm
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 CROSSROADS COMMUNITY HOSPITAL (140294) 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	131,822	19,115	-19,167	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	FAMILY MEDICINE OF MT. VERNON I	0		251,121		0	10.00
10.01	FAMILY MEDICINE OF WAYNE CITY II	0		32,845		0	10.01
10.02	FAMILY MEDICINE OF BENTON III	0		4,707		0	10.02
200.00	Total	0	131,822	307,788	-19,167	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 6/1/2014 6:46 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8 DOCTORS PARK ROAD	PO Box:			1.00
2.00	City: MT VERNON	State: IL	Zip Code: 62864	County: JEFFERSON	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	CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CROSSROADS FAMILY MED OF MT. VERNON	148983	99914		07/19/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CROSSROADS FAMILY MED OF WAYNE CITY	148980	99914		07/19/2013	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CROSSROADS FAMILY MED OF BENTON	148525	99914		07/19/2013	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	4		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)			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.	386	65	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 6/1/2014 6:46 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			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.	1		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.	01/01/2013	12/31/2013	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)	N		39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 6/1/2014 6:46 pm

		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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 6/1/2014 6:46 pm

		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.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 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.		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

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		V	XIX	
		1.00	2.00	
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)			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)			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:	37,065	42,108	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	Y	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

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		1.00	2.00	
	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	449008	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: COMMUNITY HEALTH SYSTEM PROFESSIONAL	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280		141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:			142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067		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.	Y	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	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)	0.75	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)	01/01/2013	12/31/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 6/1/2014 6:46 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N			3.00
			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.		N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		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)		Y	05/07/2014	Y	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)		N		N	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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 6/1/2014 6:46 pm

		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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N	12/31/2013	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.	PAUL	WEISSERT	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-925-4420	PAUL_WEISSERT@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 6/1/2014 6:46 pm

		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)	05/07/2014			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)				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.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 6/1/2014 6:46 pm

	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	40	14,600	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)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	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)		47	17,155	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	FAMILY MEDICINE OF MT. VERNON	88.00				0	26.00
26.01	FAMILY MEDICINE OF WAYNE CITY	88.01				0	26.01
26.02	FAMILY MEDICINE OF BENTON	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		47				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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 6/1/2014 6:46 pm

	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)	2,740	377	4,124			1.00
2.00	HMO and other (see instructions)	122	65				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,740	377	4,124			7.00
8.00	INTENSIVE CARE UNIT	356	9	516			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)	3,096	386	4,640	0.00	173.62	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	FAMILY MEDICINE OF MT. VERNON	1,638	0	2,323	0.00	1.87	26.00
26.01	FAMILY MEDICINE OF WAYNE CITY	389	0	1,313	0.00	1.17	26.01
26.02	FAMILY MEDICINE OF BENTON	77	0	402	0.00	1.44	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	178.10	27.00
28.00	Observation Bed Days		0	713			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	0	0			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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 6/1/2014 6:46 pm

	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	772	161	1,226	1.00
2.00	HMO and other (see instructions)			29			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	772	161	1,226	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	FAMILY MEDICINE OF MT. VERNON	0.00					26.00
26.01	FAMILY MEDICINE OF WAYNE CITY	0.00					26.01
26.02	FAMILY MEDICINE OF BENTON	0.00					26.02
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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 6/1/2014 6:46 pm

		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	10,036,824	0	10,036,824	370,438.00	27.09	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	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		9,360	0	9,360	96.00	97.50	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		161,050	0	161,050	1,337.14	120.44	5.00
6.00	Non-physician-Part B		290,806	0	290,806	9,323.98	31.19	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		44,895	76,291	121,186	3,400.00	35.64	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		316,527	0	316,527	6,340.70	49.92	11.00
12.00	Contract management and administrative services		37,000	0	37,000	296.00	125.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		9,375	0	9,375	223.00	42.04	13.00
14.00	Home office salaries & wage-related costs		782,087	0	782,087	15,181.00	51.52	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)		2,702,588	0	2,702,588			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		29,517	0	29,517			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		1,200	0	1,200			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		18,098	0	18,098			23.00
24.00	Wage-related costs (RHC/FQHC)		76,495	0	76,495			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	95,198	0	95,198	3,054.00	31.17	26.00
27.00	Administrative & General	5.00	1,462,318	-76,291	1,386,027	57,476.00	24.11	27.00
28.00	Administrative & General under contract (see inst.)		828	0	828	40.00	20.70	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	147,778	0	147,778	5,675.00	26.04	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	252,822	0	252,822	19,105.00	13.23	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	255,681	-101,832	153,849	9,984.97	15.41	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	101,832	101,832	6,609.03	15.41	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	744,162	0	744,162	17,637.00	42.19	38.00
39.00	Central Services and Supply	14.00	142,472	0	142,472	8,025.00	17.75	39.00
40.00	Pharmacy	15.00	322,621	0	322,621	6,693.00	48.20	40.00
41.00	Medical Records & Medical Records Library	16.00	258,127	0	258,127	13,782.00	18.73	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part II Date/Time Prepared: 6/1/2014 6:46 pm

		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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part III Date/Time Prepared: 6/1/2014 6:46 pm

		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)		9,585,796	0	9,585,796	359,816.88	26.64	1.00
2.00	Excluded area salaries (see instructions)		44,895	76,291	121,186	3,400.00	35.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,540,901	-76,291	9,464,610	356,416.88	26.55	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,144,989	0	1,144,989	22,040.70	51.95	4.00
5.00	Subtotal wage-related costs (see inst.)		2,703,788	0	2,703,788	0.00	28.57	5.00
6.00	Total (sum of lines 3 thru 5)		13,389,678	-76,291	13,313,387	378,457.58	35.18	6.00
7.00	Total overhead cost (see instructions)		3,682,007	-76,291	3,605,716	148,081.00	24.35	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part IV Date/Time Prepared: 6/1/2014 6:46 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	183,207	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)	1,419,864	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	24,988	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,995	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-6	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	6,940	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	237,438	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	582,851	17.00
18.00	Medicare Taxes - Employers Portion Only	136,312	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	101,653	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	124,658	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,827,900	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part V | Date/Time Prepared: 6/1/2014 6:46 pm

	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	353,527	0	1.00
2.00	Hospital	353,527	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			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			8.00
9.00	Hospital-Based NF			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
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

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

Provider CCN: 140294 Component CCN: 148983 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 6/1/2014 6:46 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	3050 BROADWAY	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	MT.VERNON	IL	62864	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

		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	16:30	08:00	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?		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.	N	0 13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		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		JEFFERSON				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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140294 Component CCN: 148983	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 6/1/2014 6:46 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

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

Provider CCN: 140294 Component CCN: 148980 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 6/1/2014 6:46 pm

		Rural Health Clinic (RHC) II	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	1209 W ROBINSON		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	WAYNE CITY	IL	62864 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
		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	16:30	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					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.			N	0	13.00

			Provider name	CCN number	
			1.00	2.00	
14.00	Provider name, CCN number				14.00

		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		WAYNE				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	16:30	08:00	16:30	08:00	12:00	11.00

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

Provider CCN: 140294
Component CCN: 148980

Period:
From 01/01/2013
To 12/31/2013

Worksheet S-8

Date/Time Prepared:
6/1/2014 6:46 pm

Rural Health Clinic (RHC) II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

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

Provider CCN: 140294 Component CCN: 148525 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 6/1/2014 6:46 pm

		Rural Health Clinic (RHC) III	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	905A W. WASHINGTON		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	BENTON	IL	62812 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
		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	16:30	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		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		FRANKLIN				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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140294 Component CCN: 148525	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 6/1/2014 6:46 pm
		Rural Health Clinic (RHC) III	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140294	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 6/1/2014 6:46 pm

		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)	0.161158	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,302,989	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	910,027	5.00
6.00	Medicaid charges	27,590,612	6.00
7.00	Medicaid cost (line 1 times line 6)	4,446,448	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,233,432	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)	4,933	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	17,523	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	2,824	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,233,432	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	578,532	345,535	924,067	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	93,235	55,686	148,921	21.00
22.00	Partial payment by patients approved for charity care	777	0	777	22.00
23.00	Cost of charity care (line 21 minus line 22)	92,458	55,686	148,144	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)	3,332,725	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	234,072	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,098,653	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	499,373	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	647,517	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,880,949	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,365,638	1,365,638	-9,409	1,356,229	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,901,219	1,901,219	655,747	2,556,966	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	95,198	51,382	146,580	1,988,242	2,134,822	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,462,318	13,100,445	14,562,763	-2,114,954	12,447,809	5.00
7.00	00700	OPERATION OF PLANT	147,778	1,246,578	1,394,356	-30,312	1,364,044	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,037	121,037	-325	120,712	8.00
9.00	00900	HOUSEKEEPING	252,822	51,182	304,004	0	304,004	9.00
10.00	01000	DIETARY	255,681	177,412	433,093	-172,981	260,112	10.00
11.00	01100	CAFETERIA	0	0	0	172,167	172,167	11.00
13.00	01300	NURSING ADMINISTRATION	744,162	117,758	861,920	-3,465	858,455	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	142,472	1,658,905	1,801,377	-1,443,868	357,509	14.00
15.00	01500	PHARMACY	322,621	565,113	887,734	-524,177	363,557	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	258,127	144,080	402,207	-4,693	397,514	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,041,519	652,151	1,693,670	-10,034	1,683,636	30.00
31.00	03100	INTENSIVE CARE UNIT	362,481	110,765	473,246	-1,978	471,268	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,142,387	2,738,922	3,881,309	-1,812,267	2,069,042	50.00
51.00	05100	RECOVERY ROOM	73,886	15,147	89,033	-89,033	0	51.00
53.00	05300	ANESTHESIOLOGY	0	472,798	472,798	0	472,798	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	478,958	790,780	1,269,738	-163,806	1,105,932	54.00
54.01	03630	ULTRA SOUND	93,173	98,250	191,423	0	191,423	54.01
56.00	05600	RADIOISOTOPE	20,146	236,580	256,726	0	256,726	56.00
57.00	05700	CT SCAN	99,258	96,858	196,116	-3,868	192,248	57.00
58.00	05800	MRI	0	109,090	109,090	0	109,090	58.00
60.00	06000	LABORATORY	698,753	556,291	1,255,044	31,826	1,286,870	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	125,010	125,010	-35,256	89,754	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	277	277	64.00
65.00	06500	RESPIRATORY THERAPY	283,534	74,852	358,386	0	358,386	65.00
66.00	06600	PHYSICAL THERAPY	399,773	198,102	597,875	-114,863	483,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,988	16,619	174,607	0	174,607	67.00
68.00	06800	SPEECH PATHOLOGY	35,162	3,642	38,804	0	38,804	68.00
69.00	06900	ELECTROCARDIOLOGY	163,019	32,387	195,406	-3,082	192,324	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,461,104	2,461,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	724,462	724,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	448,948	448,948	73.00
74.00	07400	RENAL DIALYSIS	0	24,640	24,640	0	24,640	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	36,288	33,451	69,739	-24,220	45,519	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	283,010	182,150	465,160	-45,473	419,687	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	75,213	79,887	155,100	-16,260	138,840	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	93,633	54,693	148,326	-16,729	131,597	88.02
90.00	09000	CLINIC	1,791	173	1,964	-1,964	0	90.00
91.00	09100	EMERGENCY	770,778	1,384,966	2,155,744	-1,016	2,154,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,991,929	28,588,953	38,580,882	-161,260	38,419,622	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	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	161,335	161,335	194.01
194.02	07954	SENIOR CIRCLE	44,895	32,689	77,584	-75	77,509	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	10,036,824	28,621,642	38,658,466	0	38,658,466	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	106,129	1,462,358		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-301,880	2,255,086		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,995	2,132,827		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,358,269	4,089,540		5.00
7.00	00700	OPERATION OF PLANT	-14,396	1,349,648		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	120,712		8.00
9.00	00900	HOUSEKEEPING	0	304,004		9.00
10.00	01000	DIETARY	0	260,112		10.00
11.00	01100	CAFETERIA	-36,507	135,660		11.00
13.00	01300	NURSING ADMINISTRATION	-6,898	851,557		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	357,509		14.00
15.00	01500	PHARMACY	0	363,557		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-895	396,619		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-346,678	1,336,958		30.00
31.00	03100	INTENSIVE CARE UNIT	0	471,268		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-66,600	2,002,442		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-442,054	30,744		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-129,652	976,280		54.00
54.01	03630	ULTRA SOUND	0	191,423		54.01
56.00	05600	RADIOISOTOPE	0	256,726		56.00
57.00	05700	CT SCAN	0	192,248		57.00
58.00	05800	MRI	0	109,090		58.00
60.00	06000	LABORATORY	-12,000	1,274,870		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	89,754		62.00
64.00	06400	INTRAVENOUS THERAPY	0	277		64.00
65.00	06500	RESPIRATORY THERAPY	0	358,386		65.00
66.00	06600	PHYSICAL THERAPY	0	483,012		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	174,607		67.00
68.00	06800	SPEECH PATHOLOGY	0	38,804		68.00
69.00	06900	ELECTROCARDIOLOGY	0	192,324		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,461,104		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	724,462		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	448,948		73.00
74.00	07400	RENAL DIALYSIS	0	24,640		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03021	SLEEP LAB	0	45,519		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY MEDICINE OF MT. VERNON	9,901	429,588		88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	3,114	141,954		88.01
88.02	08802	FAMILY MEDICINE OF BENTON	3,400	134,997		88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,080,087	1,074,641		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-10,675,367	27,744,255		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	161,335		194.01
194.02	07954	SENIOR CIRCLE	0	77,509		194.02
194.03	07953	VACANT SPACE	0	0		194.03
194.04	07952	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-10,675,367	27,983,099		200.00

RECLASSIFICATIONS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 6/1/2014 6:46 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,990,425		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	1,990,425		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	27,676		1.00
	TOTALS		0	27,676		
	C - RENTAL & LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	653,330		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	TOTALS		0	653,330		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	46,877		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	6,992		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,417		3.00
	TOTALS		0	56,286		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	76,291	85,044		1.00
	TOTALS		76,291	85,044		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,433,428		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	724,462		2.00
	TOTALS		0	3,157,890		
	G - COST OF DRUGS					
1.00	INTRAVENOUS THERAPY	64.00	0	277		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	448,948		2.00
	TOTALS		0	449,225		
	H - LAB COSTS					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	45,460	0		1.00
2.00	LABORATORY	60.00	0	80,716		2.00
	TOTALS		45,460	80,716		
	I - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	73,886	15,147		1.00
	TOTALS		73,886	15,147		
	J - CLINIC COSTS					
1.00	EMERGENCY	91.00	1,791	173		1.00
	TOTALS		1,791	173		
	K - DIETARY					
1.00	CAFETERIA	11.00	101,832	70,335		1.00
	TOTALS		101,832	70,335		
500.00	Grand Total: Increases		299,260	6,586,247		500.00

RECLASSIFICATIONS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 6/1/2014 6:46 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,894,409	0		1.00
2.00	OPERATING ROOM	50.00	0	17,554	0		2.00
3.00	FAMILY MEDICINE OF MT. VERNON	88.00	0	45,473	0		3.00
4.00	FAMILY MEDICINE OF WAYNE CITY	88.01	0	16,260	0		4.00
5.00	FAMILY MEDICINE OF BENTON	88.02	0	16,729	0		5.00
	TOTALS		0	1,990,425			
	B - OXYGEN COSTS						
1.00	OPERATION OF PLANT	7.00	0	27,676	0		1.00
	TOTALS		0	27,676			
	C - RENTAL & LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,183	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	66,202	0		2.00
3.00	OPERATION OF PLANT	7.00	0	2,636	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	325	0		4.00
5.00	DIETARY	10.00	0	814	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	3,465	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,500	0		7.00
8.00	PHARMACY	15.00	0	74,952	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,693	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	10,034	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	1,978	0		11.00
12.00	OPERATING ROOM	50.00	0	167,224	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	163,806	0		13.00
14.00	CT SCAN	57.00	0	3,868	0		14.00
15.00	LABORATORY	60.00	0	3,430	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	114,863	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	3,082	0		17.00
18.00	SLEEP LAB	76.01	0	24,220	0		18.00
19.00	EMERGENCY	91.00	0	2,980	0		19.00
20.00	SENIOR CIRCLE	194.02	0	75	0		20.00
	TOTALS		0	653,330			
	D - OTHER CAPITAL COSTS						
1.00		0.00	0	0	12		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	56,286	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	56,286			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	76,291	85,044	0		1.00
	TOTALS		76,291	85,044			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,441,368	0		1.00
2.00	OPERATING ROOM	50.00	0	1,716,522	0		2.00
	TOTALS		0	3,157,890			
	G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	449,225	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	449,225			
	H - LAB COSTS						
1.00	LABORATORY	60.00	45,460	0	0		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	80,716	0		2.00
	TOTALS		45,460	80,716			
	I - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	73,886	15,147	0		1.00
	TOTALS		73,886	15,147			
	J - CLINIC COSTS						
1.00	CLINIC	90.00	1,791	173	0		1.00
	TOTALS		1,791	173			
	K - DIETARY						
1.00	DIETARY	10.00	101,832	70,335	0		1.00
	TOTALS		101,832	70,335			
500.00	Grand Total: Decreases		299,260	6,586,247			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 6/1/2014 6:46 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	961,157	0	0	0	0	1.00
2.00	Land Improvements	500,134	9,970	0	9,970	96,936	2.00
3.00	Buildings and Fixtures	29,549,722	0	0	0	818,351	3.00
4.00	Building Improvements	5,069,107	143,310	0	143,310	0	4.00
5.00	Fixed Equipment	1,556,594	170,961	0	170,961	188,255	5.00
6.00	Movable Equipment	12,866,830	1,598,855	0	1,598,855	1,792,957	6.00
7.00	HIT designated Assets	3,174,451	912,842	0	912,842	27,109	7.00
8.00	Subtotal (sum of lines 1-7)	53,677,995	2,835,938	0	2,835,938	2,923,608	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	53,677,995	2,835,938	0	2,835,938	2,923,608	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	961,157	0	1.00
2.00	Land Improvements	413,168	0	2.00
3.00	Buildings and Fixtures	28,731,371	0	3.00
4.00	Building Improvements	5,212,417	0	4.00
5.00	Fixed Equipment	1,539,300	0	5.00
6.00	Movable Equipment	12,672,728	0	6.00
7.00	HIT designated Assets	4,060,184	0	7.00
8.00	Subtotal (sum of lines 1-7)	53,590,325	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	53,590,325	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 6/1/2014 6:46 pm

	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	CAP REL COSTS-BLDG & FIXT	1,365,638	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,901,219	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,266,857	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	CAP REL COSTS-BLDG & FIXT	0	1,365,638		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,901,219		2.00
3.00	Total (sum of lines 1-2)	0	3,266,857		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 6/1/2014 6:46 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	35,318,113	0	35,318,113	0.659039	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,272,212	0	18,272,212	0.340961	0	2.00
3.00	Total (sum of lines 1-2)	53,590,325	0	53,590,325	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,435,124	-134,483	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,486,395	653,330	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,921,519	518,847	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	CAP REL COSTS-BLDG & FIXT	0	46,877	-56,286	171,126	1,462,358	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	112,944	2,417	0	0	2,255,086	2.00
3.00	Total (sum of lines 1-2)	112,944	49,294	-56,286	171,126	3,717,444	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 6/1/2014 6:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	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	-60,948	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-13,065	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,635,017			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,071,300			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-36,507	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-895	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		0		0.00	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 - CAP REL COSTS-BLDG & FIXT	A	69,486	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-401,150	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	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
33.00	ADMIN & GENERAL ORGANIZATION COST	A	-153,259	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 6/1/2014 6:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	BAD DEBTS	A	-4,555,872	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MARKETING EXPENSE	A	-78,752	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ANASTHESIA EXPENSE	A	-442,054	ANESTHESIOLOGY	53.00	0	33.03
33.04	PHYSICIAN RECRUITING	A	-277,772	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE	A	-17,552	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	CHARITABLE EXPENSE	A	-7,640	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SPECIAL EVENTS	A	-28,094	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICAL STAFF RELATIONS	A	-26,116	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ILLINOIS PROVIDER TAX	A	-1,606,984	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	GIFT SHOP EXPENSE	A	-4,521	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	LEGAL FEES	A	-95,546	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12			0		0.00	0	33.12
33.13	TELEPHONE BENEFIT COSTS	A	-1,995	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	TELEPHONE DEPRECIATION COST	A	-609	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	TELEVISION EXPENSE	A	-14,396	OPERATION OF PLANT	7.00	0	33.15
33.16	INSERVICE EDUCATION	B	-6,898	NURSING ADMINISTRATION	13.00	0	33.16
33.17	FITNESS REVENUE	B	-580	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PENALTIES	A	-22	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PHOTO COMMISSION	B	-180	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	RURAL HEALTH CLINIC BAD DEBT	A	9,901	FAMILY MEDICINE OF MT. VERNON	88.00	0	33.20
33.21	RENTAL INCOME	B	-134,483	CAP REL COSTS-BLDG & FIXT	1.00	10	33.21
33.22	OTHER MISCELLANEOUS REVENUE	B	-89,061	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	RURAL HEALTH CLINIC II BAD DEBT	A	3,114	FAMILY MEDICINE OF WAYNE CITY	88.01	0	33.23
33.24	RURAL HEALTH CLINIC III BAD DEBT	A	3,400	FAMILY MEDICINE OF BENTON	88.02	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,675,367				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 6/1/2014 6:46 pm

	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	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	141,717	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - OPERATIN	57,835	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	294,803	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	16,330	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	8,169	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	13,079	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	104,775	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	796,266	0	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	79,173	528,956	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	517,652	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	577,240	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	1,106	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	21,533	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	311,125	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	11,366	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	58,045	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	0	4,255	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	31,701	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	19,648	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	17,654	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	9,477	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	381,044	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	33,606	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	59,039	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,512,147	2,583,447	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:					
6.00	B		0.00	CHSPSC	100.00	6.00
7.00	B		0.00	PASI	100.00	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

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.

(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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 6/1/2014 6:46 pm

	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	141,717	14		1.00
2.00	57,835	0		2.00
3.00	294,803	0		3.00
4.00	16,330	14		4.00
4.01	8,169	11		4.01
4.02	13,079	14		4.02
4.03	104,775	11		4.03
4.04	796,266	0		4.04
4.05	-449,783	0		4.05
4.06	-517,652	0		4.06
4.07	-577,240	0		4.07
4.08	-1,106	0		4.08
4.09	-21,533	0		4.09
4.10	-311,125	0		4.10
4.11	-11,366	0		4.11
4.12	-58,045	0		4.12
4.13	-4,255	0		4.13
4.14	-31,701	0		4.14
4.15	-19,648	0		4.15
4.16	-17,654	0		4.16
4.17	-9,477	0		4.17
4.18	-381,044	0		4.18
4.19	-33,606	0		4.19
4.20	-59,039	0		4.20
5.00	-1,071,300			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	CHAIN OPERATOR		6.00
7.00	COLLECTION SERV		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:

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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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 6/1/2014 6:46 pm

	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	13.00	NURSING ADMINISTRATION	9,375	0	9,375	159,800	223	1.00
2.00	30.00	ADULTS & PEDIATRICS	346,678	346,678	0	0	0	2.00
3.00	50.00	OPERATING ROOM	66,600	66,600	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	129,652	129,652	0	0	0	4.00
5.00	60.00	LABORATORY	12,000	12,000	0	0	0	5.00
6.00	91.00	EMERGENCY	1,080,087	1,080,087	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,644,392	1,635,017	9,375		223	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	13.00	NURSING ADMINISTRATION	17,132	857	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			17,132	857	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	13.00	NURSING ADMINISTRATION	0	17,132	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	346,678		2.00
3.00	50.00	OPERATING ROOM	0	0	0	66,600		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	129,652		4.00
5.00	60.00	LABORATORY	0	0	0	12,000		5.00
6.00	91.00	EMERGENCY	0	0	0	1,080,087		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	17,132	0	1,635,017		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,462,358	1,462,358				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,255,086		2,255,086			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,132,827	9,033	13,930	2,155,790		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,089,540	172,502	266,014	300,549	4,828,605	5.00
7.00	00700	OPERATION OF PLANT	1,349,648	276,208	425,938	32,045	2,083,839	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	120,712	6,194	9,552	0	136,458	8.00
9.00	00900	HOUSEKEEPING	304,004	46,568	71,811	54,823	477,206	9.00
10.00	01000	DIETARY	260,112	43,515	67,105	33,361	404,093	10.00
11.00	01100	CAFETERIA	135,660	0	0	22,082	157,742	11.00
13.00	01300	NURSING ADMINISTRATION	851,557	14,408	22,218	161,368	1,049,551	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	357,509	30,768	47,447	30,894	466,618	14.00
15.00	01500	PHARMACY	363,557	11,423	17,615	69,959	462,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	396,619	27,985	43,156	55,974	523,734	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,336,958	252,464	389,322	225,848	2,204,592	30.00
31.00	03100	INTENSIVE CARE UNIT	471,268	53,895	83,111	78,602	686,876	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,002,442	157,724	243,224	263,743	2,667,133	50.00
51.00	05100	RECOVERY ROOM	0	15,575	24,018	0	39,593	51.00
53.00	05300	ANESTHESIOLOGY	30,744	1,919	2,959	0	35,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	976,280	48,756	75,186	103,860	1,204,082	54.00
54.01	03630	ULTRA SOUND	191,423	5,700	8,790	20,204	226,117	54.01
56.00	05600	RADIOISOTOPE	256,726	4,791	7,389	4,369	273,275	56.00
57.00	05700	CT SCAN	192,248	0	0	21,524	213,772	57.00
58.00	05800	MRI	109,090	0	0	0	109,090	58.00
60.00	06000	LABORATORY	1,274,870	33,517	51,687	141,663	1,501,737	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	89,754	1,706	2,630	9,858	103,948	62.00
64.00	06400	INTRAVENOUS THERAPY	277	0	0	0	277	64.00
65.00	06500	RESPIRATORY THERAPY	358,386	15,328	23,637	61,483	458,834	65.00
66.00	06600	PHYSICAL THERAPY	483,012	6,172	9,517	86,689	585,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	174,607	0	0	34,259	208,866	67.00
68.00	06800	SPEECH PATHOLOGY	38,804	0	0	7,625	46,429	68.00
69.00	06900	ELECTROCARDIOLOGY	192,324	0	0	35,350	227,674	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,461,104	0	0	0	2,461,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	724,462	0	0	0	724,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	448,948	0	0	0	448,948	73.00
74.00	07400	RENAL DIALYSIS	24,640	2,615	4,032	0	31,287	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	45,519	18,661	28,776	7,869	100,825	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	429,588	0	0	61,369	490,957	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	141,954	0	0	16,310	158,264	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	134,997	0	0	20,304	155,301	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,074,641	70,491	108,703	167,528	1,421,363	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,744,255	1,327,918	2,047,767	2,129,512	27,376,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,320	6,662	0	10,982	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,197	6,472	0	10,669	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	161,335	2,300	3,547	16,543	183,725	194.01
194.02	07954	SENIOR CIRCLE	77,509	15,205	23,447	9,735	125,896	194.02
194.03	07953	VACANT SPACE	0	108,418	167,191	0	275,609	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	27,983,099	1,462,358	2,255,086	2,155,790	27,983,099	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,828,605					5.00
7.00	00700	OPERATION OF PLANT	434,562	2,518,401				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,457	15,527	180,442			8.00
9.00	00900	HOUSEKEEPING	99,516	116,737	5,413	698,872		9.00
10.00	01000	DIETARY	84,269	109,086	10,827	31,950	640,225	10.00
11.00	01100	CAFETERIA	32,895	0	0	0	348,056	11.00
13.00	01300	NURSING ADMINISTRATION	218,872	36,118	0	10,579	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,308	77,131	0	22,591	0	14.00
15.00	01500	PHARMACY	96,461	28,636	0	8,387	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,219	70,155	0	20,548	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	459,743	632,885	52,924	185,365	249,389	30.00
31.00	03100	INTENSIVE CARE UNIT	143,240	135,106	6,622	39,571	31,206	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	556,190	395,387	36,088	115,804	0	50.00
51.00	05100	RECOVERY ROOM	8,257	39,044	0	11,435	0	51.00
53.00	05300	ANESTHESIOLOGY	7,429	4,810	0	1,409	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	251,098	122,222	10,827	35,798	0	54.00
54.01	03630	ULTRA SOUND	47,154	14,290	0	4,185	0	54.01
56.00	05600	RADIOISOTOPE	56,988	12,011	0	3,518	0	56.00
57.00	05700	CT SCAN	44,580	0	0	0	0	57.00
58.00	05800	MRI	22,750	0	0	0	0	58.00
60.00	06000	LABORATORY	313,171	84,023	0	24,609	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	21,677	4,276	0	1,252	0	62.00
64.00	06400	INTRAVENOUS THERAPY	58	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	95,685	38,425	0	11,254	0	65.00
66.00	06600	PHYSICAL THERAPY	122,077	15,471	0	4,531	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,557	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,682	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	47,479	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	513,236	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	151,079	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,623	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	6,525	6,554	0	1,920	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	21,026	46,779	0	13,701	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	102,384	0	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	33,004	0	0	0	0	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	32,386	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	296,410	176,709	57,741	51,756	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,702,047	2,181,382	180,442	600,163	628,651	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,290	10,830	0	3,172	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,225	10,520	0	3,081	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	38,314	5,767	0	1,689	0	194.01
194.02	07954	SENIOR CIRCLE	26,254	38,115	0	11,164	0	194.02
194.03	07953	VACANT SPACE	57,475	271,787	0	79,603	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	11,574	194.04
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)	4,828,605	2,518,401	180,442	698,872	640,225	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	538,693					11.00
13.00	01300	NURSING ADMINISTRATION	35,376	1,350,496				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,103	0	679,751			14.00
15.00	01500	PHARMACY	13,433	0	1,238	610,709		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,658	0	1,144	0	752,458	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,268	267,105	12,067	0	26,475	30.00
31.00	03100	INTENSIVE CARE UNIT	20,859	92,961	2,656	0	4,897	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,597	311,923	7,976	0	147,621	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	5,439	0	75,889	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,460	122,832	4,327	0	30,904	54.00
54.01	03630	ULTRA SOUND	7,175	23,895	408	0	8,778	54.01
56.00	05600	RADIOISOTOPE	1,794	5,167	693	0	7,810	56.00
57.00	05700	CT SCAN	8,218	25,455	4,795	0	81,560	57.00
58.00	05800	MRI	0	0	471	0	7,771	58.00
60.00	06000	LABORATORY	56,026	167,542	55,588	0	124,567	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,880	11,659	113	0	2,881	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	377	4,239	64.00
65.00	06500	RESPIRATORY THERAPY	19,899	72,714	3,794	0	8,606	65.00
66.00	06600	PHYSICAL THERAPY	21,693	0	2,027	0	12,161	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,967	0	487	0	5,598	67.00
68.00	06800	SPEECH PATHOLOGY	1,794	0	10	0	851	68.00
69.00	06900	ELECTROCARDIOLOGY	19,690	41,807	115	0	19,241	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	430,537	0	18,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	128,178	0	53,552	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	610,332	26,995	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	385	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	2,503	9,306	241	0	5,357	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	7,801	0	1,240	0	977	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	4,881	0	1,209	0	752	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	6,007	0	466	0	156	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	49,769	198,130	10,808	0	76,313	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	531,851	1,350,496	676,027	610,709	752,458	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	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,463	0	662	0	0	194.01
194.02	07954	SENIOR CIRCLE	3,379	0	3,062	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	538,693	1,350,496	679,751	610,709	752,458	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,174,813	0	4,174,813		30.00
31.00	03100	INTENSIVE CARE UNIT	1,163,994	0	1,163,994		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,318,719	0	4,318,719		50.00
51.00	05100	RECOVERY ROOM	98,329	0	98,329		51.00
53.00	05300	ANESTHESIOLOGY	130,598	0	130,598		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,817,550	0	1,817,550		54.00
54.01	03630	ULTRA SOUND	332,002	0	332,002		54.01
56.00	05600	RADIOISOTOPE	361,256	0	361,256		56.00
57.00	05700	CT SCAN	378,380	0	378,380		57.00
58.00	05800	MRI	140,082	0	140,082		58.00
60.00	06000	LABORATORY	2,327,263	0	2,327,263		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	149,686	0	149,686		62.00
64.00	06400	INTRAVENOUS THERAPY	4,951	0	4,951		64.00
65.00	06500	RESPIRATORY THERAPY	709,211	0	709,211		65.00
66.00	06600	PHYSICAL THERAPY	763,350	0	763,350		66.00
67.00	06700	OCCUPATIONAL THERAPY	265,475	0	265,475		67.00
68.00	06800	SPEECH PATHOLOGY	58,766	0	58,766		68.00
69.00	06900	ELECTROCARDIOLOGY	356,006	0	356,006		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,422,999	0	3,422,999		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,057,271	0	1,057,271		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,179,898	0	1,179,898		73.00
74.00	07400	RENAL DIALYSIS	46,671	0	46,671		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03021	SLEEP LAB	199,738	0	199,738		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FAMILY MEDICINE OF MT. VERNON	603,359	0	603,359		88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	198,110	0	198,110		88.01
88.02	08802	FAMILY MEDICINE OF BENTON	194,316	0	194,316		88.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	2,338,999	0	2,338,999		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,791,792	0	26,791,792		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,274	0	27,274		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,495	0	26,495		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	233,620	0	233,620		194.01
194.02	07954	SENIOR CIRCLE	207,870	0	207,870		194.02
194.03	07953	VACANT SPACE	684,474	0	684,474		194.03
194.04	07952	GUEST MEALS	11,574	0	11,574		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	27,983,099	0	27,983,099		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,033	13,930	22,963	22,963	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	172,502	266,014	438,516	3,201	5.00
7.00	00700	OPERATION OF PLANT	0	276,208	425,938	702,146	341	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,194	9,552	15,746	0	8.00
9.00	00900	HOUSEKEEPING	0	46,568	71,811	118,379	584	9.00
10.00	01000	DIETARY	0	43,515	67,105	110,620	355	10.00
11.00	01100	CAFETERIA	0	0	0	0	235	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,408	22,218	36,626	1,719	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,768	47,447	78,215	329	14.00
15.00	01500	PHARMACY	0	11,423	17,615	29,038	745	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,985	43,156	71,141	596	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	252,464	389,322	641,786	2,406	30.00
31.00	03100	INTENSIVE CARE UNIT	0	53,895	83,111	137,006	837	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	157,724	243,224	400,948	2,810	50.00
51.00	05100	RECOVERY ROOM	0	15,575	24,018	39,593	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,919	2,959	4,878	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,756	75,186	123,942	1,106	54.00
54.01	03630	ULTRA SOUND	0	5,700	8,790	14,490	215	54.01
56.00	05600	RADIOISOTOPE	0	4,791	7,389	12,180	47	56.00
57.00	05700	CT SCAN	0	0	0	0	229	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	33,517	51,687	85,204	1,509	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,706	2,630	4,336	105	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,328	23,637	38,965	655	65.00
66.00	06600	PHYSICAL THERAPY	0	6,172	9,517	15,689	923	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	365	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	81	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,615	4,032	6,647	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	18,661	28,776	47,437	84	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	0	0	0	654	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	0	0	0	174	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	0	0	0	216	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	70,491	108,703	179,194	1,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,327,918	2,047,767	3,375,685	22,683	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,320	6,662	10,982	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,197	6,472	10,669	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,300	3,547	5,847	176	194.01
194.02	07954	SENIOR CIRCLE	0	15,205	23,447	38,652	104	194.02
194.03	07953	VACANT SPACE	0	108,418	167,191	275,609	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	0	1,462,358	2,255,086	3,717,444	22,963	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	441,717					5.00
7.00	00700	OPERATION OF PLANT	39,753	742,240				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,603	4,576	22,925			8.00
9.00	00900	HOUSEKEEPING	9,104	34,406	688	163,161		9.00
10.00	01000	DIETARY	7,709	32,151	1,376	7,459	159,670	10.00
11.00	01100	CAFETERIA	3,009	0	0	0	86,804	11.00
13.00	01300	NURSING ADMINISTRATION	20,022	10,645	0	2,470	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,902	22,733	0	5,274	0	14.00
15.00	01500	PHARMACY	8,824	8,440	0	1,958	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,991	20,677	0	4,797	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,057	186,524	6,724	43,279	62,197	30.00
31.00	03100	INTENSIVE CARE UNIT	13,104	39,819	841	9,238	7,783	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,879	116,531	4,585	27,036	0	50.00
51.00	05100	RECOVERY ROOM	755	11,507	0	2,670	0	51.00
53.00	05300	ANESTHESIOLOGY	680	1,418	0	329	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,970	36,022	1,376	8,357	0	54.00
54.01	03630	ULTRA SOUND	4,314	4,212	0	977	0	54.01
56.00	05600	RADIOISOTOPE	5,213	3,540	0	821	0	56.00
57.00	05700	CT SCAN	4,078	0	0	0	0	57.00
58.00	05800	MRI	2,081	0	0	0	0	58.00
60.00	06000	LABORATORY	28,649	24,764	0	5,745	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,983	1,260	0	292	0	62.00
64.00	06400	INTRAVENOUS THERAPY	5	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,753	11,325	0	2,627	0	65.00
66.00	06600	PHYSICAL THERAPY	11,167	4,560	0	1,058	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,985	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	886	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,343	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,950	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,821	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,565	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	597	1,932	0	448	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	1,923	13,787	0	3,199	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	9,366	0	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	3,019	0	0	0	0	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	2,963	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	27,115	52,081	7,335	12,083	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	430,138	642,910	22,925	140,117	156,784	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	210	3,192	0	741	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	204	3,101	0	719	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,505	1,700	0	394	0	194.01
194.02	07954	SENIOR CIRCLE	2,402	11,234	0	2,606	0	194.02
194.03	07953	VACANT SPACE	5,258	80,103	0	18,584	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	2,886	194.04
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)	441,717	742,240	22,925	163,161	159,670	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	90,048					11.00
13.00	01300	NURSING ADMINISTRATION	5,913	77,395				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,692	0	118,145			14.00
15.00	01500	PHARMACY	2,245	0	215	51,465		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,623	0	199	0	112,024	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,088	15,307	2,097	0	3,943	30.00
31.00	03100	INTENSIVE CARE UNIT	3,487	5,327	462	0	729	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,473	17,879	1,386	0	21,953	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	945	0	11,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,927	7,039	752	0	4,602	54.00
54.01	03630	ULTRA SOUND	1,199	1,369	71	0	1,307	54.01
56.00	05600	RADIOISOTOPE	300	296	120	0	1,163	56.00
57.00	05700	CT SCAN	1,374	1,459	833	0	12,146	57.00
58.00	05800	MRI	0	0	82	0	1,157	58.00
60.00	06000	LABORATORY	9,365	9,601	9,661	0	18,550	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	649	668	20	0	429	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	32	631	64.00
65.00	06500	RESPIRATORY THERAPY	3,326	4,167	659	0	1,282	65.00
66.00	06600	PHYSICAL THERAPY	3,626	0	352	0	1,811	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,165	0	85	0	834	67.00
68.00	06800	SPEECH PATHOLOGY	300	0	2	0	127	68.00
69.00	06900	ELECTROCARDIOLOGY	3,291	2,396	20	0	2,865	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	74,831	0	2,699	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	22,278	0	7,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	51,433	4,020	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	57	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	418	533	42	0	798	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	1,304	0	216	0	146	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	816	0	210	0	112	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	1,004	0	81	0	23	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,319	11,354	1,879	0	11,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,904	77,395	117,498	51,465	112,024	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	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	579	0	115	0	0	194.01
194.02	07954	SENIOR CIRCLE	565	0	532	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	90,048	77,395	118,145	51,465	112,024	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,020,408	0	1,020,408		30.00
31.00	03100	INTENSIVE CARE UNIT	218,633	0	218,633		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	657,480	0	657,480		50.00
51.00	05100	RECOVERY ROOM	54,525	0	54,525		51.00
53.00	05300	ANESTHESIOLOGY	19,551	0	19,551		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,093	0	212,093		54.00
54.01	03630	ULTRA SOUND	28,154	0	28,154		54.01
56.00	05600	RADIOISOTOPE	23,680	0	23,680		56.00
57.00	05700	CT SCAN	20,119	0	20,119		57.00
58.00	05800	MRI	3,320	0	3,320		58.00
60.00	06000	LABORATORY	193,048	0	193,048		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,742	0	9,742		62.00
64.00	06400	INTRAVENOUS THERAPY	668	0	668		64.00
65.00	06500	RESPIRATORY THERAPY	71,759	0	71,759		65.00
66.00	06600	PHYSICAL THERAPY	39,186	0	39,186		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,434	0	6,434		67.00
68.00	06800	SPEECH PATHOLOGY	1,396	0	1,396		68.00
69.00	06900	ELECTROCARDIOLOGY	13,292	0	13,292		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124,480	0	124,480		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,074	0	44,074		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,018	0	64,018		73.00
74.00	07400	RENAL DIALYSIS	9,681	0	9,681		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03021	SLEEP LAB	68,221	0	68,221		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FAMILY MEDICINE OF MT. VERNON	11,686	0	11,686		88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	4,331	0	4,331		88.01
88.02	08802	FAMILY MEDICINE OF BENTON	4,287	0	4,287		88.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	312,509	0	312,509		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,236,775	0	3,236,775		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,125	0	15,125		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,693	0	14,693		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	12,316	0	12,316		194.01
194.02	07954	SENIOR CIRCLE	56,095	0	56,095		194.02
194.03	07953	VACANT SPACE	379,554	0	379,554		194.03
194.04	07952	GUEST MEALS	2,886	0	2,886		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,717,444	0	3,717,444		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	CAP REL COSTS-BLDG & FIXT	130,322					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		130,322				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	805	805	9,941,626			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,373	15,373	1,386,027	-4,828,605	23,154,494	5.00
7.00	00700	OPERATION OF PLANT	24,615	24,615	147,778	0	2,083,839	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	136,458	8.00
9.00	00900	HOUSEKEEPING	4,150	4,150	252,822	0	477,206	9.00
10.00	01000	DIETARY	3,878	3,878	153,849	0	404,093	10.00
11.00	01100	CAFETERIA	0	0	101,832	0	157,742	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	1,284	744,162	0	1,049,551	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	2,742	142,472	0	466,618	14.00
15.00	01500	PHARMACY	1,018	1,018	322,621	0	462,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	2,494	258,127	0	523,734	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,499	22,499	1,041,519	0	2,204,592	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	4,803	362,481	0	686,876	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,056	14,056	1,216,273	0	2,667,133	50.00
51.00	05100	RECOVERY ROOM	1,388	1,388	0	0	39,593	51.00
53.00	05300	ANESTHESIOLOGY	171	171	0	0	35,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	4,345	478,958	0	1,204,082	54.00
54.01	03630	ULTRA SOUND	508	508	93,173	0	226,117	54.01
56.00	05600	RADIOISOTOPE	427	427	20,146	0	273,275	56.00
57.00	05700	CT SCAN	0	0	99,258	0	213,772	57.00
58.00	05800	MRI	0	0	0	0	109,090	58.00
60.00	06000	LABORATORY	2,987	2,987	653,293	0	1,501,737	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	152	45,460	0	103,948	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	277	64.00
65.00	06500	RESPIRATORY THERAPY	1,366	1,366	283,534	0	458,834	65.00
66.00	06600	PHYSICAL THERAPY	550	550	399,773	0	585,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	157,988	0	208,866	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	35,162	0	46,429	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	163,019	0	227,674	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,461,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	724,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	448,948	73.00
74.00	07400	RENAL DIALYSIS	233	233	0	0	31,287	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	1,663	1,663	36,288	0	100,825	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	0	283,010	0	490,957	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	0	75,213	0	158,264	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	0	93,633	0	155,301	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,282	6,282	772,569	0	1,421,363	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,341	118,341	9,820,440	-4,828,605	22,547,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	385	0	0	10,982	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	374	0	0	10,669	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	205	76,291	0	183,725	194.01
194.02	07954	SENIOR CIRCLE	1,355	1,355	44,895	0	125,896	194.02
194.03	07953	VACANT SPACE	9,662	9,662	0	0	275,609	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	1,462,358	2,255,086	2,155,790		4,828,605	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.221114	17.303955	0.216845		0.208539	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			22,963		441,717	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002310		0.019077	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 6/1/2014 6:46 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	89,529					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	197,497				8.00
9.00	00900	HOUSEKEEPING	4,150	5,925	84,827			9.00
10.00	01000	DIETARY	3,878	11,850	3,878	34,241		10.00
11.00	01100	CAFETERIA	0	0	0	18,615	12,913	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	0	1,284	0	848	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	0	2,742	0	386	14.00
15.00	01500	PHARMACY	1,018	0	1,018	0	322	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	0	2,494	0	663	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,499	57,926	22,499	13,338	2,020	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	7,248	4,803	1,669	500	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,056	39,499	14,056	0	1,932	50.00
51.00	05100	RECOVERY ROOM	1,388	0	1,388	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	0	171	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	11,850	4,345	0	850	54.00
54.01	03630	ULTRA SOUND	508	0	508	0	172	54.01
56.00	05600	RADIOISOTOPE	427	0	427	0	43	56.00
57.00	05700	CT SCAN	0	0	0	0	197	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,987	0	2,987	0	1,343	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	0	152	0	93	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,366	0	1,366	0	477	65.00
66.00	06600	PHYSICAL THERAPY	550	0	550	0	520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	167	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	43	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	472	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	233	0	233	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	1,663	0	1,663	0	60	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	0	0	0	187	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	0	0	0	117	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	0	0	0	144	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,282	63,199	6,282	0	1,193	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,548	197,497	72,846	33,622	12,749	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	385	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	374	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	0	205	0	83	194.01
194.02	07954	SENIOR CIRCLE	1,355	0	1,355	0	81	194.02
194.03	07953	VACANT SPACE	9,662	0	9,662	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	619	0	194.04
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)	2,518,401	180,442	698,872	640,225	538,693	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.129444	0.913644	8.238792	18.697614	41.717107	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	742,240	22,925	163,161	159,670	90,048	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.290498	0.116078	1.923456	4.663123	6.973438	205.00

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		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,265,971					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,841,974				14.00
15.00	01500	PHARMACY	0	6,998	449,225			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,466	0	166,245,701		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,041,519	68,202	0	5,849,455		30.00
31.00	03100	INTENSIVE CARE UNIT	362,481	15,010	0	1,081,913		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,216,274	45,083	0	32,609,615		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	30,744	0	16,767,396		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	478,958	24,454	0	6,828,183		54.00
54.01	03630	ULTRA SOUND	93,173	2,306	0	1,939,498		54.01
56.00	05600	RADIOISOTOPE	20,146	3,917	0	1,725,674		56.00
57.00	05700	CT SCAN	99,258	27,099	0	18,020,223		57.00
58.00	05800	MRI	0	2,660	0	1,716,869		58.00
60.00	06000	LABORATORY	653,293	314,183	0	27,522,645		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	45,460	637	0	636,525		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	277	936,583		64.00
65.00	06500	RESPIRATORY THERAPY	283,534	21,443	0	1,901,560		65.00
66.00	06600	PHYSICAL THERAPY	0	11,455	0	2,686,998		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,750	0	1,236,919		67.00
68.00	06800	SPEECH PATHOLOGY	0	57	0	187,978		68.00
69.00	06900	ELECTROCARDIOLOGY	163,019	648	0	4,251,215		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,433,429	0	4,004,078		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	724,462	0	11,832,020		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	448,948	5,964,322		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	85,000		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03021	SLEEP LAB	36,288	1,363	0	1,183,567		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	7,008	0	215,958		88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	6,831	0	166,099		88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	2,632	0	34,461		88.02
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	772,568	61,089	0	16,860,947		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,265,971	3,820,926	449,225	166,245,701		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	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	3,740	0	0		194.01
194.02	07954	SENIOR CIRCLE	0	17,308	0	0		194.02
194.03	07953	VACANT SPACE	0	0	0	0		194.03
194.04	07952	GUEST MEALS	0	0	0	0		194.04
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)	1,350,496	679,751	610,709	752,458		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.256457	0.176928	1.359472	0.004526		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,395	118,145	51,465	112,024		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.014697	0.030751	0.114564	0.000674		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 6/1/2014 6:46 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,174,813		4,174,813	0	4,174,813	30.00
31.00	03100	INTENSIVE CARE UNIT	1,163,994		1,163,994	0	1,163,994	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,318,719		4,318,719	0	4,318,719	50.00
51.00	05100	RECOVERY ROOM	98,329		98,329	0	98,329	51.00
53.00	05300	ANESTHESIOLOGY	130,598		130,598	0	130,598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,817,550		1,817,550	0	1,817,550	54.00
54.01	03630	ULTRA SOUND	332,002		332,002	0	332,002	54.01
56.00	05600	RADIOISOTOPE	361,256		361,256	0	361,256	56.00
57.00	05700	CT SCAN	378,380		378,380	0	378,380	57.00
58.00	05800	MRI	140,082		140,082	0	140,082	58.00
60.00	06000	LABORATORY	2,327,263		2,327,263	0	2,327,263	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	149,686		149,686	0	149,686	62.00
64.00	06400	INTRAVENOUS THERAPY	4,951		4,951	0	4,951	64.00
65.00	06500	RESPIRATORY THERAPY	709,211	0	709,211	0	709,211	65.00
66.00	06600	PHYSICAL THERAPY	763,350	0	763,350	0	763,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	265,475	0	265,475	0	265,475	67.00
68.00	06800	SPEECH PATHOLOGY	58,766	0	58,766	0	58,766	68.00
69.00	06900	ELECTROCARDIOLOGY	356,006		356,006	0	356,006	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,422,999		3,422,999	0	3,422,999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,057,271		1,057,271	0	1,057,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,179,898		1,179,898	0	1,179,898	73.00
74.00	07400	RENAL DIALYSIS	46,671		46,671	0	46,671	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03021	SLEEP LAB	199,738		199,738	0	199,738	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	603,359		603,359	0	603,359	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	198,110		198,110	0	198,110	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	194,316		194,316	0	194,316	88.02
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,338,999		2,338,999	0	2,338,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	615,390		615,390		615,390	92.00
200.00		Subtotal (see instructions)	27,407,182	0	27,407,182	0	27,407,182	200.00
201.00		Less Observation Beds	615,390		615,390		615,390	201.00
202.00		Total (see instructions)	26,791,792	0	26,791,792	0	26,791,792	202.00

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		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	5,023,701		5,023,701			30.00
31.00	03100	INTENSIVE CARE UNIT	1,081,913		1,081,913			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,952,417	22,657,198	32,609,615	0.132437	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,074,392	11,693,004	16,767,396	0.007789	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,327,946	5,500,237	6,828,183	0.266184	0.000000	54.00
54.01	03630	ULTRA SOUND	210,570	1,728,928	1,939,498	0.171179	0.000000	54.01
56.00	05600	RADIOISOTOPE	265,978	1,459,696	1,725,674	0.209342	0.000000	56.00
57.00	05700	CT SCAN	3,781,753	14,238,470	18,020,223	0.020998	0.000000	57.00
58.00	05800	MRI	54,110	1,662,759	1,716,869	0.081592	0.000000	58.00
60.00	06000	LABORATORY	6,254,617	21,268,028	27,522,645	0.084558	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	435,229	201,296	636,525	0.235161	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	451,091	485,492	936,583	0.005286	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,431,499	470,061	1,901,560	0.372963	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	758,360	1,928,638	2,686,998	0.284090	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	376,984	859,935	1,236,919	0.214626	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	38,650	149,328	187,978	0.312622	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,062,683	3,188,532	4,251,215	0.083742	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,361,413	642,665	4,004,078	0.854878	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,342,697	2,489,323	11,832,020	0.089357	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,382,414	2,581,908	5,964,322	0.197826	0.000000	73.00
74.00	07400	RENAL DIALYSIS	80,000	5,000	85,000	0.549071	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03021	SLEEP LAB	0	1,183,567	1,183,567	0.168759	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	215,958	215,958			88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	166,099	166,099			88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	34,461	34,461			88.02
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	2,411,244	14,449,703	16,860,947	0.138723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	120,680	705,074	825,754	0.745246	0.000000	92.00
200.00		Subtotal (see instructions)	56,280,341	109,965,360	166,245,701			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	56,280,341	109,965,360	166,245,701			202.00

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.132437	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.007789	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266184	54.00
54.01	03630	ULTRA SOUND	0.171179	54.01
56.00	05600	RADIOISOTOPE	0.209342	56.00
57.00	05700	CT SCAN	0.020998	57.00
58.00	05800	MRI	0.081592	58.00
60.00	06000	LABORATORY	0.084558	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.235161	62.00
64.00	06400	INTRAVENOUS THERAPY	0.005286	64.00
65.00	06500	RESPIRATORY THERAPY	0.372963	65.00
66.00	06600	PHYSICAL THERAPY	0.284090	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.214626	67.00
68.00	06800	SPEECH PATHOLOGY	0.312622	68.00
69.00	06900	ELECTROCARDIOLOGY	0.083742	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.854878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197826	73.00
74.00	07400	RENAL DIALYSIS	0.549071	74.00
76.00	03020	ACUPUNCTURE	0.000000	76.00
76.01	03021	SLEEP LAB	0.168759	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	FAMILY MEDICINE OF MT. VERNON		88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY		88.01
88.02	08802	FAMILY MEDICINE OF BENTON		88.02
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.138723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.745246	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 6/1/2014 6:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,174,813		4,174,813	0	4,174,813	30.00
31.00	03100	INTENSIVE CARE UNIT	1,163,994		1,163,994	0	1,163,994	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,318,719		4,318,719	0	4,318,719	50.00
51.00	05100	RECOVERY ROOM	98,329		98,329	0	98,329	51.00
53.00	05300	ANESTHESIOLOGY	130,598		130,598	0	130,598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,817,550		1,817,550	0	1,817,550	54.00
54.01	03630	ULTRA SOUND	332,002		332,002	0	332,002	54.01
56.00	05600	RADIOISOTOPE	361,256		361,256	0	361,256	56.00
57.00	05700	CT SCAN	378,380		378,380	0	378,380	57.00
58.00	05800	MRI	140,082		140,082	0	140,082	58.00
60.00	06000	LABORATORY	2,327,263		2,327,263	0	2,327,263	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	149,686		149,686	0	149,686	62.00
64.00	06400	INTRAVENOUS THERAPY	4,951		4,951	0	4,951	64.00
65.00	06500	RESPIRATORY THERAPY	709,211	0	709,211	0	709,211	65.00
66.00	06600	PHYSICAL THERAPY	763,350	0	763,350	0	763,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	265,475	0	265,475	0	265,475	67.00
68.00	06800	SPEECH PATHOLOGY	58,766	0	58,766	0	58,766	68.00
69.00	06900	ELECTROCARDIOLOGY	356,006		356,006	0	356,006	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,422,999		3,422,999	0	3,422,999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,057,271		1,057,271	0	1,057,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,179,898		1,179,898	0	1,179,898	73.00
74.00	07400	RENAL DIALYSIS	46,671		46,671	0	46,671	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03021	SLEEP LAB	199,738		199,738	0	199,738	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	603,359		603,359	0	603,359	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	198,110		198,110	0	198,110	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	194,316		194,316	0	194,316	88.02
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,338,999		2,338,999	0	2,338,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	615,390		615,390		615,390	92.00
200.00		Subtotal (see instructions)	27,407,182	0	27,407,182	0	27,407,182	200.00
201.00		Less Observation Beds	615,390		615,390		615,390	201.00
202.00		Total (see instructions)	26,791,792	0	26,791,792	0	26,791,792	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 6/1/2014 6:46 pm

Title XIX | Hospital | Cost

		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	5,023,701		5,023,701			30.00
31.00	03100	INTENSIVE CARE UNIT	1,081,913		1,081,913			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,952,417	22,657,198	32,609,615	0.132437	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	5,074,392	11,693,004	16,767,396	0.007789	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,327,946	5,500,237	6,828,183	0.266184	0.000000	54.00
54.01	03630	ULTRA SOUND	210,570	1,728,928	1,939,498	0.171179	0.000000	54.01
56.00	05600	RADIOISOTOPE	265,978	1,459,696	1,725,674	0.209342	0.000000	56.00
57.00	05700	CT SCAN	3,781,753	14,238,470	18,020,223	0.020998	0.000000	57.00
58.00	05800	MRI	54,110	1,662,759	1,716,869	0.081592	0.000000	58.00
60.00	06000	LABORATORY	6,254,617	21,268,028	27,522,645	0.084558	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	435,229	201,296	636,525	0.235161	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	451,091	485,492	936,583	0.005286	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,431,499	470,061	1,901,560	0.372963	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	758,360	1,928,638	2,686,998	0.284090	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	376,984	859,935	1,236,919	0.214626	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	38,650	149,328	187,978	0.312622	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,062,683	3,188,532	4,251,215	0.083742	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,361,413	642,665	4,004,078	0.854878	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,342,697	2,489,323	11,832,020	0.089357	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,382,414	2,581,908	5,964,322	0.197826	0.000000	73.00
74.00	07400	RENAL DIALYSIS	80,000	5,000	85,000	0.549071	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03021	SLEEP LAB	0	1,183,567	1,183,567	0.168759	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	215,958	215,958	2.793872	0.000000	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	166,099	166,099	1.192722	0.000000	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	34,461	34,461	5.638722	0.000000	88.02
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	2,411,244	14,449,703	16,860,947	0.138723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	120,680	705,074	825,754	0.745246	0.000000	92.00
200.00		Subtotal (see instructions)	56,280,341	109,965,360	166,245,701			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	56,280,341	109,965,360	166,245,701			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 6/1/2014 6:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03021	SLEEP LAB	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0.000000		88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0.000000		88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part I | Date/Time Prepared: 6/1/2014 6:46 pm

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	1,020,408	0	1,020,408	4,837	210.96	30.00
31.00	INTENSIVE CARE UNIT	218,633		218,633	516	423.71	31.00
200.00	Total (lines 30-199)	1,239,041		1,239,041	5,353		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	2,740	578,030				30.00
31.00	INTENSIVE CARE UNIT	356	150,841				31.00
200.00	Total (lines 30-199)	3,096	728,871				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 6/1/2014 6:46 pm

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	657,480	32,609,615	0.020162	5,208,139	105,006	50.00
51.00	05100	RECOVERY ROOM	54,525	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	19,551	16,767,396	0.001166	2,650,858	3,091	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,093	6,828,183	0.031061	924,955	28,730	54.00
54.01	03630	ULTRA SOUND	28,154	1,939,498	0.014516	133,652	1,940	54.01
56.00	05600	RADIOISOTOPE	23,680	1,725,674	0.013722	187,626	2,575	56.00
57.00	05700	CT SCAN	20,119	18,020,223	0.001116	2,304,305	2,572	57.00
58.00	05800	MRI	3,320	1,716,869	0.001934	39,200	76	58.00
60.00	06000	LABORATORY	193,048	27,522,645	0.007014	4,349,367	30,506	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,742	636,525	0.015305	337,033	5,158	62.00
64.00	06400	INTRAVENOUS THERAPY	668	936,583	0.000713	316,691	226	64.00
65.00	06500	RESPIRATORY THERAPY	71,759	1,901,560	0.037737	932,720	35,198	65.00
66.00	06600	PHYSICAL THERAPY	39,186	2,686,998	0.014584	511,848	7,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,434	1,236,919	0.005202	234,812	1,221	67.00
68.00	06800	SPEECH PATHOLOGY	1,396	187,978	0.007426	30,484	226	68.00
69.00	06900	ELECTROCARDIOLOGY	13,292	4,251,215	0.003127	780,452	2,440	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124,480	4,004,078	0.031088	2,420,222	75,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,074	11,832,020	0.003725	4,927,642	18,355	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,018	5,964,322	0.010733	2,285,963	24,535	73.00
74.00	07400	RENAL DIALYSIS	9,681	85,000	0.113894	50,000	5,695	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03021	SLEEP LAB	68,221	1,183,567	0.057640	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	11,686	215,958	0.054112	0	0	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	4,331	166,099	0.026075	0	0	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	4,287	34,461	0.124401	0	0	88.02
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	312,509	16,860,947	0.018534	1,555,353	28,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	150,414	825,754	0.182154	66,467	12,107	92.00
200.00		Total (lines 50-199)	2,148,148	160,140,087		30,247,789	391,189	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part III Date/Time Prepared: 6/1/2014 6:46 pm

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
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	4,837	0.00	2,740	0		30.00
31.00	03100	INTENSIVE CARE UNIT	516	0.00	356	0		31.00
200.00		Total (lines 30-199)	5,353		3,096	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 6/1/2014 6:46 pm

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	0	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	0	0	0	0	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 6/1/2014 6:46 pm

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	32,609,615	0.000000	0.000000	5,208,139	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	16,767,396	0.000000	0.000000	2,650,858	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,828,183	0.000000	0.000000	924,955	54.00
54.01	03630	ULTRA SOUND	0	1,939,498	0.000000	0.000000	133,652	54.01
56.00	05600	RADIOISOTOPE	0	1,725,674	0.000000	0.000000	187,626	56.00
57.00	05700	CT SCAN	0	18,020,223	0.000000	0.000000	2,304,305	57.00
58.00	05800	MRI	0	1,716,869	0.000000	0.000000	39,200	58.00
60.00	06000	LABORATORY	0	27,522,645	0.000000	0.000000	4,349,367	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	636,525	0.000000	0.000000	337,033	62.00
64.00	06400	INTRAVENOUS THERAPY	0	936,583	0.000000	0.000000	316,691	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,901,560	0.000000	0.000000	932,720	65.00
66.00	06600	PHYSICAL THERAPY	0	2,686,998	0.000000	0.000000	511,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,236,919	0.000000	0.000000	234,812	67.00
68.00	06800	SPEECH PATHOLOGY	0	187,978	0.000000	0.000000	30,484	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,251,215	0.000000	0.000000	780,452	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,004,078	0.000000	0.000000	2,420,222	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,832,020	0.000000	0.000000	4,927,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,964,322	0.000000	0.000000	2,285,963	73.00
74.00	07400	RENAL DIALYSIS	0	85,000	0.000000	0.000000	50,000	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03021	SLEEP LAB	0	1,183,567	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	215,958	0.000000	0.000000	0	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	166,099	0.000000	0.000000	0	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	34,461	0.000000	0.000000	0	88.02
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	16,860,947	0.000000	0.000000	1,555,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	825,754	0.000000	0.000000	66,467	92.00
200.00		Total (lines 50-199)	0	160,140,087			30,247,789	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 6/1/2014 6:46 pm

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	6,868,857	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	3,317,302	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,783,504	0		54.00
54.01	03630	ULTRA SOUND	0	767,250	0		54.01
56.00	05600	RADIOISOTOPE	0	770,099	0		56.00
57.00	05700	CT SCAN	0	4,855,404	0		57.00
58.00	05800	MRI	0	583,200	0		58.00
60.00	06000	LABORATORY	0	160,750	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	134,548	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	229,140	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	188,970	0		65.00
66.00	06600	PHYSICAL THERAPY	0	652	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,516	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,531,516	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	340,081	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	726,904	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	923,120	0		73.00
74.00	07400	RENAL DIALYSIS	0	2,500	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03021	SLEEP LAB	0	461,463	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	0	0		88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	0	0		88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	3,093,452	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	285,716	0		92.00
200.00		Total (lines 50-199)	0	27,025,944	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 6/1/2014 6:46 pm

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	0.132437	6,868,857	0	0	909,691	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.007789	3,317,302	0	0	25,838	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266184	1,783,504	0	0	474,740	54.00
54.01	03630	ULTRA SOUND	0.171179	767,250	0	0	131,337	54.01
56.00	05600	RADIOISOTOPE	0.209342	770,099	0	0	161,214	56.00
57.00	05700	CT SCAN	0.020998	4,855,404	0	0	101,954	57.00
58.00	05800	MRI	0.081592	583,200	0	0	47,584	58.00
60.00	06000	LABORATORY	0.084558	160,750	741	0	13,593	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.235161	134,548	0	0	31,640	62.00
64.00	06400	INTRAVENOUS THERAPY	0.005286	229,140	0	0	1,211	64.00
65.00	06500	RESPIRATORY THERAPY	0.372963	188,970	0	0	70,479	65.00
66.00	06600	PHYSICAL THERAPY	0.284090	652	0	0	185	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.214626	1,516	0	0	325	67.00
68.00	06800	SPEECH PATHOLOGY	0.312622	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.083742	1,531,516	0	0	128,252	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.854878	340,081	0	0	290,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089357	726,904	0	0	64,954	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197826	923,120	0	0	182,617	73.00
74.00	07400	RENAL DIALYSIS	0.549071	2,500	0	0	1,373	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0.168759	461,463	0	0	77,876	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0.000000				0	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0.000000				0	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0.000000				0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.138723	3,093,452	0	0	429,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.745246	285,716	0	0	212,929	92.00
200.00		Subtotal (see instructions)		27,025,944	741	0	3,357,653	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		27,025,944	741	0	3,357,653	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 6/1/2014 6:46 pm

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
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	63	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03021	SLEEP LAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0	0		88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0	0		88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	63	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	63	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 6/1/2014 6:46 pm

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)	4,837	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,837	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)	4,124	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)	2,740	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)	4,174,813	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)	4,174,813	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)	4,174,813	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)	863.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,364,894	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,364,894	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 6/1/2014 6:46 pm

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	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	1,163,994	516	2,255.80	356	803,065	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)	5,391,904	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,559,863	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)	728,871	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	391,189	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,120,060	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,439,803	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)	713	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	863.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	615,390	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 6/1/2014 6:46 pm

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	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	1,020,408	4,174,813	0.244420	615,390	150,414	90.00
91.00	Nursing School cost	0	4,174,813	0.000000	615,390	0	91.00
92.00	Allied health cost	0	4,174,813	0.000000	615,390	0	92.00
93.00	All other Medical Education	0	4,174,813	0.000000	615,390	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 6/1/2014 6:46 pm

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		3,353,654		30.00
31.00	03100	INTENSIVE CARE UNIT		744,077		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.132437	5,208,139	689,750	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.007789	2,650,858	20,648	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266184	924,955	246,208	54.00
54.01	03630	ULTRA SOUND	0.171179	133,652	22,878	54.01
56.00	05600	RADIOISOTOPE	0.209342	187,626	39,278	56.00
57.00	05700	CT SCAN	0.020998	2,304,305	48,386	57.00
58.00	05800	MRI	0.081592	39,200	3,198	58.00
60.00	06000	LABORATORY	0.084558	4,349,367	367,774	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.235161	337,033	79,257	62.00
64.00	06400	INTRAVENOUS THERAPY	0.005286	316,691	1,674	64.00
65.00	06500	RESPIRATORY THERAPY	0.372963	932,720	347,870	65.00
66.00	06600	PHYSICAL THERAPY	0.284090	511,848	145,411	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.214626	234,812	50,397	67.00
68.00	06800	SPEECH PATHOLOGY	0.312622	30,484	9,530	68.00
69.00	06900	ELECTROCARDIOLOGY	0.083742	780,452	65,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.854878	2,420,222	2,068,995	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.089357	4,927,642	440,319	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197826	2,285,963	452,223	73.00
74.00	07400	RENAL DIALYSIS	0.549071	50,000	27,454	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03021	SLEEP LAB	0.168759	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FAMILY MEDICINE OF MT. VERNON	0.000000		0	88.00
88.01	08801	FAMILY MEDICINE OF WAYNE CITY	0.000000		0	88.01
88.02	08802	FAMILY MEDICINE OF BENTON	0.000000		0	88.02
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.138723	1,555,353	215,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.745246	66,467	49,534	92.00
200.00		Total (sum of lines 50-94 and 96-98)		30,247,789	5,391,904	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)		30,247,789		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Date/Time Prepared: 6/1/2014 6:46 pm

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)		3,699,554		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		1,017,275		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)		276,867		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		208,686		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		45.05		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)		7.77		30.00
31.00	Percentage of Medicaid patient days (see instructions)		9.72		31.00
32.00	Sum of lines 30 and 31		17.49		32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.12		33.00
34.00	Disproportionate share adjustment (see instructions)		162,900		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Date/Time Prepared: 6/1/2014 6:46 pm

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)			0.000024348	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			220,263	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			55,518	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		55,518		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)		5,212,114		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		6,706,399		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		6,332,828		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		424,553		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)		6,757,381		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,757,381		61.00
62.00	Deductibles billed to program beneficiaries		642,744		62.00
63.00	Coinsurance billed to program beneficiaries		12,728		63.00
64.00	Allowable bad debts (see instructions)		196,526		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		127,742		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		177,143		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,229,651		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	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		8,070		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-47,520		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)	0	0		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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E Part A Date/Time Prepared: 6/1/2014 6:46 pm

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)		6,190,201		71.00
71.01	Sequestration adjustment (see instructions)		93,472		71.01
72.00	Interim payments		5,964,907		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		131,822		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		514,658		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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140294	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 6/1/2014 6:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	63	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,357,653	2.00
3.00	PPS payments	2,872,549	3.00
4.00	Outlier payment (see instructions)	32,697	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.855	5.00
6.00	Line 2 times line 5	2,870,793	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)	63	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	741	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)	741	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)	741	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	678	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)	63	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)	2,905,246	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	709,324	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)	2,195,985	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)	2,195,985	30.00
31.00	Primary payer payments	1,608	31.00
32.00	Subtotal (line 30 minus line 31)	2,194,377	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)	163,585	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	106,330	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	153,684	36.00
37.00	Subtotal (see instructions)	2,300,707	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	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)	2,300,707	40.00
40.01	Sequestration adjustment (see instructions)	34,741	40.01
41.00	Interim payments	2,246,851	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	19,115	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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 6/1/2014 6:46 pm

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		5,964,907		2,246,851	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)		5,964,907		2,246,851	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		131,822		19,115	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,096,729		2,265,966	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: 140294 | Component CCN: 14U294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 6/1/2014 6:46 pm

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		0		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)		0		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)		0		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: 140294	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 6/1/2014 6:46 pm
	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	1,226	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	3,096	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	122	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	4,640	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	166,245,701	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	924,067	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)	1,054,155	8.00
9.00	Sequestration adjustment amount (see instructions)	21,083	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,033,072	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,052,239	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)	-19,167	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140294 | Component CCN: 14U294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-2 | Date/Time Prepared: 6/1/2014 6:46 pm

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)	0	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	0	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)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	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)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	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	0	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G | Date/Time Prepared: 6/1/2014 6:46 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-132,931	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	-5,156,696	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,192,070	0	0	0	6.00
7.00	Inventory	1,995,366	0	0	0	7.00
8.00	Prepaid expenses	257,563	0	0	0	8.00
9.00	Other current assets	329,678	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)	-3,899,090	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	961,157	0	0	0	12.00
13.00	Land improvements	413,167	0	0	0	13.00
14.00	Accumulated depreciation	-131,528	0	0	0	14.00
15.00	Buildings	28,732,145	0	0	0	15.00
16.00	Accumulated depreciation	-8,007,231	0	0	0	16.00
17.00	Leasehold improvements	5,224,046	0	0	0	17.00
18.00	Accumulated depreciation	-1,855,139	0	0	0	18.00
19.00	Fixed equipment	1,558,433	0	0	0	19.00
20.00	Accumulated depreciation	-662,269	0	0	0	20.00
21.00	Automobiles and trucks	43,741	0	0	0	21.00
22.00	Accumulated depreciation	-19,941	0	0	0	22.00
23.00	Major movable equipment	10,105,575	0	0	0	23.00
24.00	Accumulated depreciation	-5,720,000	0	0	0	24.00
25.00	Minor equipment depreciable	3,276,493	0	0	0	25.00
26.00	Accumulated depreciation	-1,528,164	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	32,390,485	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	2,864,755	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,864,755	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,356,150	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,039,576	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,143,711	0	0	0	38.00
39.00	Payroll taxes payable	159,504	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-61,277,929	0	0	0	43.00
44.00	Other current liabilities	137,819	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-57,797,319	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-57,797,319	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	89,153,469				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)	89,153,469	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,356,150	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-1 | Date/Time Prepared: 6/1/2014 6:46 pm

		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		82,078,176		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,075,296				2.00
3.00	Total (sum of line 1 and line 2)		89,153,472		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		89,153,472		0		11.00
12.00	ROUNDING	3		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)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		89,153,469		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			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	ROUNDING		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: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/1/2014 6:46 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,023,701		5,023,701	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,023,701		5,023,701	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,081,913		1,081,913	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)	1,081,913		1,081,913	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,105,614		6,105,614	17.00
18.00	Ancillary services	47,642,803	94,394,065	142,036,868	18.00
19.00	Outpatient services	2,531,924	15,154,777	17,686,701	19.00
20.00	FAMILY MEDICINE OF MT. VERNON	0	215,958	215,958	20.00
20.01	FAMILY MEDICINE OF WAYNE CITY	0	166,099	166,099	20.01
20.02	FAMILY MEDICINE OF BENTON	0	34,461	34,461	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	56,280,341	109,965,360	166,245,701	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,658,466		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		38,658,466		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-3 | Date/Time Prepared: 6/1/2014 6:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	166,245,701	1.00
2.00	Less contractual allowances and discounts on patients' accounts	122,116,887	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,128,814	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,658,466	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,470,348	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,604,948	24.00
25.00	Total other income (sum of lines 6-24)	1,604,948	25.00
26.00	Total (line 5 plus line 25)	7,075,296	26.00
27.00		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)	7,075,296	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet L Parts I-III Date/Time Prepared: 6/1/2014 6:46 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	370,011	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	54,542	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)	12.71	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)	424,553	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: 140294 Component CCN: 148983 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 6/1/2014 6:46 pm

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	141,454	0	141,454	0	141,454	1.00
2.00	Physician Assistant	28,844	0	28,844	0	28,844	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	42,124	0	42,124	0	42,124	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	212,422	0	212,422	0	212,422	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	1,867	1,867	0	1,867	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	1,250	1,250	0	1,250	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	3,117	3,117	0	3,117	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	212,422	3,117	215,539	0	215,539	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	622	622	0	622	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	622	622	0	622	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	45,780	45,780	0	45,780	29.00
30.00	Administrative Costs	70,588	132,631	203,219	-45,473	157,746	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	70,588	178,411	248,999	-45,473	203,526	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	283,010	182,150	465,160	-45,473	419,687	32.00

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

Provider CCN: 140294 | Component CCN: 148983 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	141,454		1.00
2.00	Physician Assistant	0	28,844		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	42,124		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	212,422		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	1,867		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	1,250		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	3,117		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	215,539		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	622		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	622		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	45,780		29.00
30.00	Administrative Costs	9,901	167,647		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	9,901	213,427		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	9,901	429,588		32.00

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

Provider CCN: 140294 Component CCN: 148980 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	38,307	0	38,307	0	38,307	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	13,910	0	13,910	0	13,910	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	10,989	10,989	0	10,989	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)	52,217	10,989	63,206	0	63,206	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	642	642	0	642	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	642	642	0	642	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	52,217	11,631	63,848	0	63,848	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	15,016	15,016	0	15,016	29.00
30.00	Administrative Costs	22,996	53,240	76,236	-16,260	59,976	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	22,996	68,256	91,252	-16,260	74,992	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	75,213	79,887	155,100	-16,260	138,840	32.00

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

Provider CCN: 140294 | Component CCN: 148980 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	38,307		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	13,910		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	10,989		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	63,206		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	642		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	642		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	63,848		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	15,016		29.00
30.00	Administrative Costs	3,114	63,090		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	3,114	78,106		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,114	141,954		32.00

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

Provider CCN: 140294 Component CCN: 148525 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) III | 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	19,897	0	19,897	0	19,897	1.00
2.00	Physician Assistant	29,612	0	29,612	0	29,612	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	13,541	0	13,541	0	13,541	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	1,877	1,877	0	1,877	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)	63,050	1,877	64,927	0	64,927	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	1,082	1,082	0	1,082	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	1,082	1,082	0	1,082	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	63,050	2,959	66,009	0	66,009	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	8,770	8,770	0	8,770	29.00
30.00	Administrative Costs	30,583	42,964	73,547	-16,729	56,818	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	30,583	51,734	82,317	-16,729	65,588	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	93,633	54,693	148,326	-16,729	131,597	32.00

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

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	19,897		1.00
2.00	Physician Assistant	0	29,612		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	13,541		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	1,877		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	64,927		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	1,082		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	1,082		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	66,009		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	8,770		29.00
30.00	Administrative Costs	3,400	60,218		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	3,400	68,988		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,400	134,997		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148983 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.26	2,323	4,200	1,092		1.00
2.00	Physician Assistant	0.26	0	0	0		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1-3)	0.52	2,323		1,092	2,323	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.52	2,323			2,323	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					215,539	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					622	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					216,161	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.997123	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					213,427	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					173,771	15.00
16.00	Total overhead (sum of lines 14 and 15)					387,198	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					387,198	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					386,084	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					601,623	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140294 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2

Component CCN: 148980 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.38	1,313	2,100	798		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1-3)	0.38	1,313		798	1,313	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.38	1,313			1,313	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					63,848	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					63,848	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					78,106	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					56,156	15.00
16.00	Total overhead (sum of lines 14 and 15)					134,262	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					134,262	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					134,262	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					198,110	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.12	99	4,200	504		1.00
2.00	Physician Assistant	0.46	303	2,100	966		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1-3)	0.58	402		1,470	1,470	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.58	402			1,470	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					66,009	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					66,009	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					68,988	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					59,319	15.00
16.00	Total overhead (sum of lines 14 and 15)					128,307	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					128,307	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					128,307	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					194,316	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148983 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-3 | Date/Time Prepared: 6/1/2014 6:46 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		601,623	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		7,668	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		593,955	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,323	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,323	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		255.68	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)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	255.68	255.68	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,638	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	418,804	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		418,804	16.00
16.01	Total program charges (see instructions)(from contractor's records)		237,960	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		333,766	16.04
16.05	Total program cost (see instructions)		333,766	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,596	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		47,273	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		333,766	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,668	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		341,434	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		341,434	26.00
26.01	Sequestration adjustment (see instructions)		5,156	26.01
27.00	Interim payments		85,157	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		251,121	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148980 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-3 | Date/Time Prepared: 6/1/2014 6:46 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		198,110	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		9,423	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		188,687	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,313	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,313	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		143.71	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)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	143.71	143.71	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	389	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	55,903	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		55,903	16.00
16.01	Total program charges (see instructions)(from contractor's records)		51,022	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		44,156	16.04
16.05	Total program cost (see instructions)		44,156	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		708	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,063	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		44,156	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,423	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		53,579	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		53,579	26.00
26.01	Sequestration adjustment (see instructions)		809	26.01
27.00	Interim payments		19,925	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		32,845	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-3 | Date/Time Prepared: 6/1/2014 6:46 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		194,316	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		818	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		193,498	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,470	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,470	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		131.63	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)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	131.63	131.63	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	77	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	10,136	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		10,136	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		7,951	16.04
16.05	Total program cost (see instructions)		7,951	16.05
17.00	Primary payer amounts		11	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		197	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,241	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		7,940	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		818	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		8,758	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		8,758	26.00
26.01	Sequestration adjustment (see instructions)		132	26.01
27.00	Interim payments		3,919	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		4,707	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: 140294 | Component CCN: 148983 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-4 | Date/Time Prepared: 6/1/2014 6:46 pm

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)	212,422	212,422	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.010559	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	2,243	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	499	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	2,742	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	215,539	215,539	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	387,198	387,198	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.012722	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	4,926	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	7,668	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	46	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	166.70	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	46	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	7,668	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)		7,668	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)		7,668	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 140294 Component CCN: 148980	Period: From 01/01/2013 To 12/31/2013	Worksheet M-4 Date/Time Prepared: 6/1/2014 6:46 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	63,206	63,206	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003964	0.019253	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	251	1,217	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	831	738	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,082	1,955	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	63,848	63,848	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	134,262	134,262	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016946	0.030620	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,275	4,111	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,357	6,066	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	68	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	239.79	89.21	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	14	68	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,357	6,066	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)		9,423	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)		9,423	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-4 | Date/Time Prepared: 6/1/2014 6:46 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	64,927	64,927	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.002765	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	180	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	98	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	278	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	66,009	66,009	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	128,307	128,307	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.004212	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	540	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	818	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	9	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	90.89	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	9	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	818	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)		818	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)		818	16.00

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

Provider CCN: 140294 Component CCN: 148983 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		85,157	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		85,157	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		251,121	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		336,278	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140294 Component CCN: 148980 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		19,925	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		19,925	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		32,845	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		52,770	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140294 Component CCN: 148525 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 6/1/2014 6:46 pm

Rural Health Clinic (RHC) III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		3,919	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		3,919	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		4,707	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		8,626	7.00

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