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: 141320	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/23/2014 11:47 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/23/2014 Time: 11:47 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARIS COMMUNITY HOSPITAL (141320) 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	569,406	297,646	479,006	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	40,748	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		126,903		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-1,531		0	10.01
10.02	RURAL HEALTH CLINIC III	0		422		0	10.02
200.00	Total	0	610,154	423,440	479,006	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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2014 10:53 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 721 EAST COURT STREET	PO Box:			1.00
2.00	City: PARIS	State: IL	Zip Code: 61944-	County: EDGAR	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	PARIS COMMUNITY HOSPITAL	141320	14999	1	06/30/2002	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARIS COMMUNITY HOSPITAL	14Z320	14999		06/30/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FMC	143987	14999		09/24/1994	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HATCH	143989	14999		01/01/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	FMC	143431	14999		02/16/1997	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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	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.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2014 10:53 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2014 10:53 am

		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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2014 10:53 am

		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)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		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.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	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.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141320	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/23/2014 10:53 am

		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)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

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

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

		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)	514,941	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2014 10:53 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		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.		Y	C	05/20/2012	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	04/13/2014	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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2014 10:53 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAKE	CARNAZZO	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476	JCARNAZZO@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2014 10:53 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/13/2014			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.		REIMBURSEMENT 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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2014 10:53 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	32,784.00	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)		25	9,125	32,784.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	32,784.00	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	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2014 10:53 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	945	91	1,366			1.00
2.00	HMO and other (see instructions)	23	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	580	0	580			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	3,084			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,525	91	5,030			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)	1,525	91	5,030	0.00	183.92	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	RURAL HEALTH CLINIC	8,186	0	33,252	0.00	54.03	26.00
26.01	RURAL HEALTH CLINIC II	364	0	2,464	0.00	3.13	26.01
26.02	RURAL HEALTH CLINIC III	108	0	625	0.00	1.20	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	242.28	27.00
28.00	Observation Bed Days		0	229			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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2014 10:53 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	305	40	470	1.00
2.00	HMO and other (see instructions)			8			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	305	40	470	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	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	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 RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part IV Date/Time Prepared: 5/23/2014 10:53 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	363,257	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)	3,347,360	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	77,522	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	47,017	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	118,293	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	942,383	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	19,665	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	2,900	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,918,397	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

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

Provider CCN: 141320 Component CCN: 143987 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 5/23/2014 10:53 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	727 EAST COURT STREET	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	PARIS IL	61944 2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
9.01		0	9.01
9.02		0	9.02
9.03		0	9.03
9.04		0	9.04
9.05		0	9.05
9.06		0	9.06
9.07		0	9.07
9.08		0	9.08
9.09		0	9.09
9.10		0	9.10
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	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)	N	0	0	0	0	15.00

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

Provider CCN: 141320
Component CCN: 143987

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

Worksheet S-8

Date/Time Prepared:
5/23/2014 10:53 am

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		EDGAR				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	17:00	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	19:00	08:00	11:30		11.00

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

Provider CCN: 141320 | Component CCN: 143989 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 5/23/2014 10:53 am

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	144 ILLINOIS	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	CHRISMAN	IL	61924	2.00

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

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	12:00	13:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 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)	N	0	0	0	0	15.00

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

Provider CCN: 141320
Component CCN: 143989

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

Worksheet S-8

Date/Time Prepared:
5/23/2014 10:53 am

Rural Health Clinic (RHC) II

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		EDGAR				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:30			08:00	12:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00				11.00

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

Provider CCN: 141320 | Component CCN: 143431 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 5/23/2014 10:53 am

		Rural Health Clinic (RHC) III	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	104 BUENA VISTA	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	KANSAS	IL	61933	2.00

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

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:30	12:00		11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	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)	N	0	0	0	0	15.00

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

Provider CCN: 141320
Component CCN: 143431
Period: From 01/01/2013 To 12/31/2013
Worksheet S-8
Date/Time Prepared: 5/23/2014 10:53 am

Rural Health Clinic (RHC) III
Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		EDGAR				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		08:30	12:00	13:30	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141320	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/23/2014 10:53 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.453439	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,007,094	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	13,229,190	6.00
7.00	Medicaid cost (line 1 times line 6)	5,998,631	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,991,537	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,991,537	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	2,757,436	676,043	3,433,479	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,250,329	306,544	1,556,873	21.00
22.00	Partial payment by patients approved for charity care	3,894	4,619	8,513	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,246,435	301,925	1,548,360	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,906,783	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	767,192	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,139,591	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	970,174	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,518,534	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,510,071	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,034,902	1,034,902	241,286	1,276,188	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,036,572	1,036,572	169,420	1,205,992	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	148,800	4,016,224	4,165,024	-276,360	3,888,664	4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL	1,263,054	3,847,693	5,110,747	-166,107	4,944,640	5.01
5.02	00560	ADMITTING	530,504	209,239	739,743	-1,050	738,693	5.02
7.00	00700	OPERATION OF PLANT	363,205	564,452	927,657	-1,116	926,541	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,632	124,632	0	124,632	8.00
9.00	00900	HOUSEKEEPING	184,810	56,002	240,812	0	240,812	9.00
10.00	01000	DIETARY	387,364	202,108	589,472	-492,981	96,491	10.00
11.00	01100	CAFETERIA	0	0	0	492,981	492,981	11.00
13.00	01300	NURSING ADMINISTRATION	613,609	81,641	695,250	0	695,250	13.00
15.00	01500	PHARMACY	206,732	1,058,294	1,265,026	-1,019,255	245,771	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	283,789	73,823	357,612	0	357,612	16.00
17.00	01700	SOCIAL SERVICE	0	48,052	48,052	0	48,052	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,218,963	274,792	1,493,755	-21,688	1,472,067	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	870,866	2,213,419	3,084,285	-1,820,991	1,263,294	50.00
53.00	05300	ANESTHESIOLOGY	495,471	220,390	715,861	130,697	846,558	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,290,064	768,078	2,058,142	105,798	2,163,940	54.00
60.00	06000	LABORATORY	675,800	776,968	1,452,768	-196	1,452,572	60.00
65.00	06500	RESPIRATORY THERAPY	220,944	51,939	272,883	-39,895	232,988	65.00
66.00	06600	PHYSICAL THERAPY	709,000	175,422	884,422	0	884,422	66.00
69.00	06900	ELECTROCARDIOLOGY	0	42,023	42,023	48,071	90,094	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,310	5,310	0	5,310	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	891,460	891,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	986,237	986,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,057,502	1,057,502	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,877,051	1,065,842	3,942,893	-20,900	3,921,993	88.00
88.01	08801	RURAL HEALTH CLINIC II	206,925	114,567	321,492	-29,704	291,788	88.01
88.02	08802	RURAL HEALTH CLINIC III	106,025	51,734	157,759	-16,384	141,375	88.02
90.00	09000	CLINIC	93,817	51,744	145,561	-14,760	130,801	90.00
90.01	09001	OP CLINIC	376,174	164,830	541,004	0	541,004	90.01
90.02	09002	SENIOR CARE	4,757	428,083	432,840	-22,800	410,040	90.02
91.00	09100	EMERGENCY	1,152,431	1,911,786	3,064,217	0	3,064,217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		163,974	163,974	-163,974	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,280,155	20,834,535	35,114,690	15,291	35,129,981	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,726,621	360,595	2,087,216	-15,291	2,071,925	192.00
200.00		TOTAL (SUM OF LINES 118-199)	16,006,776	21,195,130	37,201,906	0	37,201,906	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-237,691	1,038,497		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-197,082	1,008,910		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,888,664		4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL	-1,195,522	3,749,118		5.01
5.02	00560	ADMITTING	0	738,693		5.02
7.00	00700	OPERATION OF PLANT	0	926,541		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,632		8.00
9.00	00900	HOUSEKEEPING	0	240,812		9.00
10.00	01000	DIETARY	0	96,491		10.00
11.00	01100	CAFETERIA	-424,338	68,643		11.00
13.00	01300	NURSING ADMINISTRATION	0	695,250		13.00
15.00	01500	PHARMACY	0	245,771		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,620	351,992		16.00
17.00	01700	SOCIAL SERVICE	0	48,052		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-122,320	1,349,747		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-13,265	1,250,029		50.00
53.00	05300	ANESTHESIOLOGY	-813,566	32,992		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-772,317	1,391,623		54.00
60.00	06000	LABORATORY	0	1,452,572		60.00
65.00	06500	RESPIRATORY THERAPY	0	232,988		65.00
66.00	06600	PHYSICAL THERAPY	0	884,422		66.00
69.00	06900	ELECTROCARDIOLOGY	-41,189	48,905		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-4,963	347		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-130	891,330		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	986,237		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-29,939	1,027,563		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-144,055	3,777,938		88.00
88.01	08801	RURAL HEALTH CLINIC II	-3,455	288,333		88.01
88.02	08802	RURAL HEALTH CLINIC III	-936	140,439		88.02
90.00	09000	CLINIC	-14,490	116,311		90.00
90.01	09001	OP CLINIC	-91,679	449,325		90.01
90.02	09002	SENIOR CARE	-4,158	405,882		90.02
91.00	09100	EMERGENCY	-1,397,537	1,666,680		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,514,252	29,615,729		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-19,963	2,051,962		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-5,534,215	31,667,691		200.00

RECLASSIFICATIONS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/23/2014 10:53 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	169,420		1.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
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	169,420		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	323,956	169,025		1.00
	TOTALS		323,956	169,025		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	33,311	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		33,311	0		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	77,312		1.00
	TOTALS		0	77,312		
	E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	99,137		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	99,137		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,057,502		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,057,502		
	H - TELEPHONE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	38,360		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	38,360		
	I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	9,513	5,247		1.00
	TOTALS		9,513	5,247		
	J - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	792,323		1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	986,237		2.00
	TOTALS		0	1,778,560		
	K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	163,974		1.00
	TOTALS		0	163,974		
	L - ANESTHESIA BENEFITS					
1.00	ANESTHESIOLOGY	53.00	0	132,315		1.00
	TOTALS		0	132,315		
	M - RADIOLOGY BENEFITS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	141,595		1.00
	TOTALS		0	141,595		
	N - WOUND CARE BENEFITS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,450		1.00
	TOTALS		0	2,450		
500.00	Grand Total: Increases		366,780	3,834,897		500.00

RECLASSIFICATIONS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/23/2014 10:53 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL EXPENSE						
1.00		0.00	0	0	10		1.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	47,075	0		3.00
4.00	ADMITTING	5.02	0	1,050	0		4.00
5.00	OPERATION OF PLANT	7.00	0	1,116	0		5.00
9.00	ADULTS & PEDIATRICS	30.00	0	4,954	0		9.00
10.00	OPERATING ROOM	50.00	0	42,431	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	1,618	0		11.00
13.00	LABORATORY	60.00	0	196	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	4,261	0		14.00
15.00	SENIOR CARE	90.02	0	22,800	0		15.00
17.00	RURAL HEALTH CLINIC	88.00	0	6,762	0		17.00
18.00	RURAL HEALTH CLINIC II	88.01	0	18,881	0		18.00
19.00	RURAL HEALTH CLINIC III	88.02	0	8,048	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10,228	0		20.00
	TOTALS		0	169,420			
	B - CAFETERIA						
1.00	DIETARY	10.00	323,956	169,025	0		1.00
	TOTALS		323,956	169,025			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	16,734	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	16,577	0	0		2.00
	TOTALS		33,311	0			
	D - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	77,312	9		1.00
	TOTALS		0	77,312			
	E - OXYGEN/PATIENT SUPPLIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	80,080	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	19,057	0		2.00
	TOTALS		0	99,137			
	F - DRUGS						
1.00	PHARMACY	15.00	0	1,019,255	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38,247	0		2.00
	TOTALS		0	1,057,502			
	H - TELEPHONE						
1.00		0.00	0	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	14,138	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	10,823	0		3.00
4.00	RURAL HEALTH CLINIC III	88.02	0	8,336	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,063	0		5.00
	TOTALS		0	38,360			
	I - STRESS TEST						
1.00	CLINIC	90.00	9,513	5,247	0		1.00
	TOTALS		9,513	5,247			
	J - MED SUPPLIES						
1.00	OPERATING ROOM	50.00	0	1,778,560	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,778,560			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	163,974	9		1.00
	TOTALS		0	163,974			
	L - ANESTHESIA BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	0	132,315	0		1.00
	TOTALS		0	132,315			
	M - RADIOLOGY BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	0	141,595	0		1.00
	TOTALS		0	141,595			
	N - WOUND CARE BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	0	2,450	0		1.00
	TOTALS		0	2,450			
500.00	Grand Total: Decreases		366,780	3,834,897			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part I Date/Time Prepared: 5/23/2014 10:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	39,160	2,106	0	2,106	0	1.00
2.00	Land Improvements	1,815,667	12,259	0	12,259	0	2.00
3.00	Buildings and Fixtures	21,328,212	1,272,600	0	1,272,600	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	9,410,934	3,946,931	0	3,946,931	143,898	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,593,973	5,233,896	0	5,233,896	143,898	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,593,973	5,233,896	0	5,233,896	143,898	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	41,266	0	1.00
2.00	Land Improvements	1,827,926	0	2.00
3.00	Buildings and Fixtures	22,600,812	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	13,213,967	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,683,971	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,683,971	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 5/23/2014 10:53 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,034,902	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,036,572	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,071,474	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,034,902		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,036,572		2.00
3.00	Total (sum of lines 1-2)	0	2,071,474		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2014 10:53 am

	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	NEW CAP REL COSTS-BLDG & FIXT	1,034,902	0	1,034,902	0.499597	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,036,572	0	1,036,572	0.500403	0	2.00
3.00	Total (sum of lines 1-2)	2,071,474	0	2,071,474	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,038,497	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,036,572	169,420	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,075,069	169,420	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,038,497	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-197,082	0	0	0	1,008,910	2.00
3.00	Total (sum of lines 1-2)	-197,082	0	0	0	2,047,407	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/23/2014 10:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-157,015	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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)	B	-14,732	OTHER ADMINISTRATIVE AND GENERAL	5.01	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,702,736			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-424,338	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-80,676	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-130	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-29,939	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,620	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/23/2014 10:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	PHYSICIAN RECRUTING	A	-8,467	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
34.00	ADVERTISING	A	-57,462	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	34.00
35.00			0		0.00	0	35.00
36.00	ADVERTISING	A	-34,762	RURAL HEALTH CLINIC	88.00	0	36.00
37.00	ADVERTISING	A	-3,455	RURAL HEALTH CLINIC II	88.01	0	37.00
38.00	ADVERTISING	A	-936	RURAL HEALTH CLINIC III	88.02	0	38.00
39.00	ADVERTISING	A	-9,963	PHYSICIANS' PRIVATE OFFICES	192.00	0	39.00
40.00	ANESTHESIA	A	-659,992	ANESTHESIOLOGY	53.00	0	40.00
41.00	ANESTHESIA OTHER	A	-153,574	ANESTHESIOLOGY	53.00	0	41.00
42.00	OTHER REVENUE	B	28,221	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42.00
43.00	CPR	B	-3,469	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	43.00
44.00	IHA	A	-13,806	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	44.00
45.00	FMC OTHER REVENUE	B	-109,293	RURAL HEALTH CLINIC	88.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03	FMC OTHER REVENUE	B	-10,000	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.03
45.04	AHA	A	-2,918	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.04
45.05	HOSPITAL ASSESSMENT	A	-1,093,359	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.05
45.06			0		0.00	0	45.06
45.07	RADIOLOGY	A	-619,094	RADIOLOGY-DIAGNOSTIC	54.00	0	45.07
45.08	RADIOLOGY OTHER	A	-152,958	RADIOLOGY-DIAGNOSTIC	54.00	0	45.08
45.09	WOUND CARE	A	-9,173	OP CLINIC	90.01	0	45.09
45.10	WOUND CARE OTHER	A	-2,939	OP CLINIC	90.01	0	45.10
45.11			0		0.00	0	45.11
45.12	MCHC DUES	A	-125	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.12
45.13	ADVERTISING	A	-4,158	SENIOR CARE	90.02	0	45.13
45.14	RADIOLOGY REVENUE	B	-265	RADIOLOGY-DIAGNOSTIC	54.00	0	45.14
45.15	MEANINGFUL USE ACCELERATED PAYMENT	A	-197,082	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,534,215				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2014 10:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	29,405	29,405	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	122,320	122,320	0	0	0	2.00
3.00	50.00	OPERATING ROOM	13,265	13,265	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	41,189	41,189	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	4,963	4,963	0	0	0	5.00
6.00	90.00	CLINIC	23,490	14,490	9,000	0	0	6.00
7.00	90.01	OP CLINIC	79,567	79,567	0	0	0	7.00
8.00	90.02	SENIOR CARE	21,500	0	21,500	0	0	8.00
9.00	91.00	EMERGENCY	1,775,500	1,397,537	377,963	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,111,199	1,702,736	408,463		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	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	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	OP CLINIC	0	0	0	0	0	7.00
8.00	90.02	SENIOR CARE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	29,405		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	122,320		2.00
3.00	50.00	OPERATING ROOM	0	0	0	13,265		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	41,189		4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	4,963		5.00
6.00	90.00	CLINIC	0	0	0	14,490		6.00
7.00	90.01	OP CLINIC	0	0	0	79,567		7.00
8.00	90.02	SENIOR CARE	0	0	0	0		8.00
9.00	91.00	EMERGENCY	0	0	0	1,397,537		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,702,736		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,038,497	1,038,497				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,008,910		1,008,910			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,888,664	7,841	7,618	3,904,123		4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL	3,749,118	208,043	202,118	332,323	4,491,602	5.01
5.02	00560	ADMITTING	738,693	25,457	24,731	139,581	928,462	5.02
7.00	00700	OPERATION OF PLANT	926,541	100,521	97,657	95,563	1,220,282	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	124,632	8,231	7,997	0	140,860	8.00
9.00	00900	HOUSEKEEPING	240,812	5,773	5,608	48,626	300,819	9.00
10.00	01000	DIETARY	96,491	24,668	23,965	16,683	161,807	10.00
11.00	01100	CAFETERIA	68,643	11,834	11,497	85,236	177,210	11.00
13.00	01300	NURSING ADMINISTRATION	695,250	11,588	11,258	161,447	879,543	13.00
15.00	01500	PHARMACY	245,771	7,316	7,107	54,393	314,587	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	351,992	18,912	18,373	74,668	463,945	16.00
17.00	01700	SOCIAL SERVICE	48,052	1,322	1,285	0	50,659	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,349,747	120,476	117,043	316,320	1,903,586	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,250,029	84,686	82,273	229,134	1,646,122	50.00
53.00	05300	ANESTHESIOLOGY	32,992	1,000	972	0	34,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,391,623	61,976	60,210	199,924	1,713,733	54.00
60.00	06000	LABORATORY	1,452,572	25,813	25,077	177,810	1,681,272	60.00
65.00	06500	RESPIRATORY THERAPY	232,988	3,196	3,105	53,771	293,060	65.00
66.00	06600	PHYSICAL THERAPY	884,422	37,282	36,220	186,546	1,144,470	66.00
69.00	06900	ELECTROCARDIOLOGY	48,905	4,442	4,315	11,267	68,929	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	347	2,797	2,718	0	5,862	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	891,330	0	0	0	891,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	986,237	0	0	0	986,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,027,563	0	0	0	1,027,563	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,777,938	124,935	121,375	756,045	4,780,293	88.00
88.01	08801	RURAL HEALTH CLINIC II	288,333	12,716	12,353	54,683	368,085	88.01
88.02	08802	RURAL HEALTH CLINIC III	140,439	6,553	6,366	27,957	181,315	88.02
90.00	09000	CLINIC	116,311	5,205	5,057	22,182	148,755	90.00
90.01	09001	OP CLINIC	449,325	25,677	24,945	98,976	598,923	90.01
90.02	09002	SENIOR CARE	405,882	13,563	13,177	1,252	433,874	90.02
91.00	09100	EMERGENCY	1,666,680	43,597	42,355	303,217	2,055,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,615,729	1,005,420	976,775	3,447,604	29,093,998	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,051,962	33,077	32,135	456,519	2,573,693	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,667,691	1,038,497	1,008,910	3,904,123	31,667,691	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL	4,491,602					5.01
5.02	00560	ADMITTING	153,454	1,081,916				5.02
7.00	00700	OPERATION OF PLANT	201,686	0	1,421,968			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,281	0	16,802	180,943		8.00
9.00	00900	HOUSEKEEPING	49,719	0	11,784	0	362,322	9.00
10.00	01000	DIETARY	26,743	0	50,353	0	13,093	10.00
11.00	01100	CAFETERIA	29,289	0	24,155	0	6,281	11.00
13.00	01300	NURSING ADMINISTRATION	145,369	0	23,654	0	6,151	13.00
15.00	01500	PHARMACY	51,994	0	14,933	0	3,883	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76,680	0	38,604	0	10,038	16.00
17.00	01700	SOCIAL SERVICE	8,373	0	2,699	0	702	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	314,621	140,730	245,915	180,943	63,945	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,068	121,696	172,860	0	44,949	50.00
53.00	05300	ANESTHESIOLOGY	5,779	2,585	2,042	0	531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	283,242	126,695	126,504	0	32,895	54.00
60.00	06000	LABORATORY	277,877	124,295	52,689	0	13,701	60.00
65.00	06500	RESPIRATORY THERAPY	48,436	21,666	6,523	0	1,696	65.00
66.00	06600	PHYSICAL THERAPY	189,156	84,610	76,100	0	19,788	66.00
69.00	06900	ELECTROCARDIOLOGY	11,392	5,096	9,067	0	2,358	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	969	433	5,710	0	1,485	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,317	65,895	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	163,003	72,912	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	169,834	75,967	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	790,070	0	255,015	0	66,311	88.00
88.01	08801	RURAL HEALTH CLINIC II	60,836	0	25,955	0	6,749	88.01
88.02	08802	RURAL HEALTH CLINIC III	29,967	0	13,375	0	3,478	88.02
90.00	09000	CLINIC	24,586	10,997	10,624	0	2,763	90.00
90.01	09001	OP CLINIC	98,989	44,278	52,412	0	13,629	90.01
90.02	09002	SENIOR CARE	71,710	32,076	27,685	0	7,199	90.02
91.00	09100	EMERGENCY	339,787	151,985	88,991	0	23,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,066,227	1,081,916	1,354,451	180,943	344,765	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	425,375	0	67,517	0	17,557	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,491,602	1,081,916	1,421,968	180,943	362,322	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	251,996					10.00
11.00	01100	CAFETERIA	0	236,935				11.00
13.00	01300	NURSING ADMINISTRATION	0	12,006	1,066,723			13.00
15.00	01500	PHARMACY	0	4,045	0	389,442		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,553	0	0	594,820	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	251,996	23,523	354,274	49	23,230	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,039	257,265	113	64,764	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15	9,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,867	0	1,036	145,326	54.00
60.00	06000	LABORATORY	0	13,223	0	1	110,437	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,999	0	489	6,634	65.00
66.00	06600	PHYSICAL THERAPY	0	13,872	0	299	62,356	66.00
69.00	06900	ELECTROCARDIOLOGY	0	838	0	0	9,697	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	38	292	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	54,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	350,887	43,519	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	56,225	0	32,412	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,066	0	1,592	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,079	0	699	0	88.02
90.00	09000	CLINIC	0	1,650	0	39	2,033	90.00
90.01	09001	OP CLINIC	0	7,360	111,064	954	6,860	90.01
90.02	09002	SENIOR CARE	0	93	1,448	0	7,571	90.02
91.00	09100	EMERGENCY	0	22,548	342,672	105	47,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	251,996	202,986	1,066,723	388,728	594,820	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,949	0	714	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	251,996	236,935	1,066,723	389,442	594,820	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	62,433					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,433	3,565,245	0	3,565,245		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,596,876	0	2,596,876		50.00
53.00	05300	ANESTHESIOLOGY	0	55,719	0	55,719		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,444,298	0	2,444,298		54.00
60.00	06000	LABORATORY	0	2,273,495	0	2,273,495		60.00
65.00	06500	RESPIRATORY THERAPY	0	382,503	0	382,503		65.00
66.00	06600	PHYSICAL THERAPY	0	1,590,651	0	1,590,651		66.00
69.00	06900	ELECTROCARDIOLOGY	0	107,377	0	107,377		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,789	0	14,789		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,158,998	0	1,158,998		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,222,152	0	1,222,152		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,667,770	0	1,667,770		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,980,326	0	5,980,326		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	467,283	0	467,283		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	230,913	0	230,913		88.02
90.00	09000	CLINIC	0	201,447	0	201,447		90.00
90.01	09001	OP CLINIC	0	934,469	0	934,469		90.01
90.02	09002	SENIOR CARE	0	581,656	0	581,656		90.02
91.00	09100	EMERGENCY	0	3,072,919	0	3,072,919		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,433	28,548,886	0	28,548,886		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,118,805	0	3,118,805		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	62,433	31,667,691	0	31,667,691		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,841	7,618	15,459	15,459	4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL	0	208,043	202,118	410,161	1,316	5.01
5.02	00560	ADMITTING	0	25,457	24,731	50,188	553	5.02
7.00	00700	OPERATION OF PLANT	0	100,521	97,657	198,178	378	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,231	7,997	16,228	0	8.00
9.00	00900	HOUSEKEEPING	0	5,773	5,608	11,381	193	9.00
10.00	01000	DIETARY	0	24,668	23,965	48,633	66	10.00
11.00	01100	CAFETERIA	0	11,834	11,497	23,331	338	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,588	11,258	22,846	639	13.00
15.00	01500	PHARMACY	0	7,316	7,107	14,423	215	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,912	18,373	37,285	296	16.00
17.00	01700	SOCIAL SERVICE	0	1,322	1,285	2,607	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	120,476	117,043	237,519	1,253	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,686	82,273	166,959	907	50.00
53.00	05300	ANESTHESIOLOGY	0	1,000	972	1,972	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	61,976	60,210	122,186	792	54.00
60.00	06000	LABORATORY	0	25,813	25,077	50,890	704	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,196	3,105	6,301	213	65.00
66.00	06600	PHYSICAL THERAPY	0	37,282	36,220	73,502	739	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,442	4,315	8,757	45	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,797	2,718	5,515	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	124,935	121,375	246,310	2,990	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	12,716	12,353	25,069	217	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	6,553	6,366	12,919	111	88.02
90.00	09000	CLINIC	0	5,205	5,057	10,262	88	90.00
90.01	09001	OP CLINIC	0	25,677	24,945	50,622	392	90.01
90.02	09002	SENIOR CARE	0	13,563	13,177	26,740	5	90.02
91.00	09100	EMERGENCY	0	43,597	42,355	85,952	1,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,005,420	976,775	1,982,195	13,651	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,077	32,135	65,212	1,808	192.00
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	1,038,497	1,008,910	2,047,407	15,459	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL	411,477					5.01
5.02	00560	ADMITTING	14,058	64,799				5.02
7.00	00700	OPERATION OF PLANT	18,476	0	217,032			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,133	0	2,564	20,925		8.00
9.00	00900	HOUSEKEEPING	4,555	0	1,798	0	17,927	9.00
10.00	01000	DIETARY	2,450	0	7,685	0	648	10.00
11.00	01100	CAFETERIA	2,683	0	3,687	0	311	11.00
13.00	01300	NURSING ADMINISTRATION	13,317	0	3,610	0	304	13.00
15.00	01500	PHARMACY	4,763	0	2,279	0	192	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,025	0	5,892	0	497	16.00
17.00	01700	SOCIAL SERVICE	767	0	412	0	35	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,822	8,429	37,533	20,925	3,164	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,924	7,289	26,383	0	2,224	50.00
53.00	05300	ANESTHESIOLOGY	529	155	312	0	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,948	7,588	19,308	0	1,628	54.00
60.00	06000	LABORATORY	25,456	7,445	8,042	0	678	60.00
65.00	06500	RESPIRATORY THERAPY	4,437	1,298	996	0	84	65.00
66.00	06600	PHYSICAL THERAPY	17,328	5,068	11,615	0	979	66.00
69.00	06900	ELECTROCARDIOLOGY	1,044	305	1,384	0	117	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	89	26	872	0	73	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,496	3,947	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,933	4,367	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,558	4,550	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	72,383	0	38,924	0	3,280	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,573	0	3,961	0	334	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,745	0	2,041	0	172	88.02
90.00	09000	CLINIC	2,252	659	1,622	0	137	90.00
90.01	09001	OP CLINIC	9,068	2,652	7,999	0	674	90.01
90.02	09002	SENIOR CARE	6,569	1,921	4,226	0	356	90.02
91.00	09100	EMERGENCY	31,128	9,100	13,582	0	1,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	372,509	64,799	206,727	20,925	17,058	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,968	0	10,305	0	869	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	411,477	64,799	217,032	20,925	17,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	59,482					10.00
11.00	01100	CAFETERIA	0	30,350				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,538	42,254			13.00
15.00	01500	PHARMACY	0	518	0	22,390		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	711	0	0	51,706	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,482	3,013	14,035	3	2,019	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,182	10,190	7	5,629	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1	852	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,904	0	60	12,637	54.00
60.00	06000	LABORATORY	0	1,694	0	0	9,599	60.00
65.00	06500	RESPIRATORY THERAPY	0	512	0	28	577	65.00
66.00	06600	PHYSICAL THERAPY	0	1,777	0	17	5,420	66.00
69.00	06900	ELECTROCARDIOLOGY	0	107	0	0	843	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2	25	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,173	3,783	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,205	0	1,863	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	521	0	92	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	266	0	40	0	88.02
90.00	09000	CLINIC	0	211	0	2	177	90.00
90.01	09001	OP CLINIC	0	943	4,399	55	596	90.01
90.02	09002	SENIOR CARE	0	12	57	0	658	90.02
91.00	09100	EMERGENCY	0	2,888	13,573	6	4,158	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,482	26,002	42,254	22,349	51,706	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,348	0	41	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	59,482	30,350	42,254	22,390	51,706	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	3,821					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,821	420,018	0	420,018		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	246,694	0	246,694		50.00
53.00	05300	ANESTHESIOLOGY	0	3,847	0	3,847		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	192,051	0	192,051		54.00
60.00	06000	LABORATORY	0	104,508	0	104,508		60.00
65.00	06500	RESPIRATORY THERAPY	0	14,446	0	14,446		65.00
66.00	06600	PHYSICAL THERAPY	0	116,445	0	116,445		66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,602	0	12,602		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,602	0	6,602		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,176	0	22,176		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	19,300	0	19,300		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,064	0	44,064		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	372,955	0	372,955		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	35,767	0	35,767		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	18,294	0	18,294		88.02
90.00	09000	CLINIC	0	15,410	0	15,410		90.00
90.01	09001	OP CLINIC	0	77,400	0	77,400		90.01
90.02	09002	SENIOR CARE	0	40,544	0	40,544		90.02
91.00	09100	EMERGENCY	0	162,733	0	162,733		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,821	1,925,856	0	1,925,856		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	121,551	0	121,551		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,821	2,047,407	0	2,047,407		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	122,507					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		122,507				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	925	925	14,838,303			4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL	24,542	24,542	1,263,054	-4,491,602	27,176,089	5.01
5.02	00560	ADMITTING	3,003	3,003	530,504	0	928,462	5.02
7.00	00700	OPERATION OF PLANT	11,858	11,858	363,205	0	1,220,282	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	140,860	8.00
9.00	00900	HOUSEKEEPING	681	681	184,810	0	300,819	9.00
10.00	01000	DIETARY	2,910	2,910	63,408	0	161,807	10.00
11.00	01100	CAFETERIA	1,396	1,396	323,956	0	177,210	11.00
13.00	01300	NURSING ADMINISTRATION	1,367	1,367	613,609	0	879,543	13.00
15.00	01500	PHARMACY	863	863	206,732	0	314,587	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	283,789	0	463,945	16.00
17.00	01700	SOCIAL SERVICE	156	156	0	0	50,659	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,212	14,212	1,202,229	0	1,903,586	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,990	9,990	870,866	0	1,646,122	50.00
53.00	05300	ANESTHESIOLOGY	118	118	0	0	34,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,311	7,311	759,845	0	1,713,733	54.00
60.00	06000	LABORATORY	3,045	3,045	675,800	0	1,681,272	60.00
65.00	06500	RESPIRATORY THERAPY	377	377	204,366	0	293,060	65.00
66.00	06600	PHYSICAL THERAPY	4,398	4,398	709,000	0	1,144,470	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	42,824	0	68,929	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	330	330	0	0	5,862	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	891,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	986,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,027,563	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,738	14,738	2,873,472	0	4,780,293	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,500	1,500	207,831	0	368,085	88.01
88.02	08802	RURAL HEALTH CLINIC III	773	773	106,256	0	181,315	88.02
90.00	09000	CLINIC	614	614	84,305	0	148,755	90.00
90.01	09001	OP CLINIC	3,029	3,029	376,174	0	598,923	90.01
90.02	09002	SENIOR CARE	1,600	1,600	4,757	0	433,874	90.02
91.00	09100	EMERGENCY	5,143	5,143	1,152,431	0	2,055,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,605	118,605	13,103,223	-4,491,602	24,602,396	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,902	3,902	1,735,080	0	2,573,693	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,038,497	1,008,910	3,904,123		4,491,602	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.477042	8.235529	0.263111		0.165278	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,459		411,477	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001042		0.015141	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	ADMITTING (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING	14,634,529					5.02
7.00	00700	OPERATION OF PLANT	0	82,179				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100			8.00
9.00	00900	HOUSEKEEPING	0	681	0	80,527		9.00
10.00	01000	DIETARY	0	2,910	0	2,910	100	10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,367	0	1,367	0	13.00
15.00	01500	PHARMACY	0	863	0	863	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	0	16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,903,586	14,212	100	14,212	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,646,122	9,990	0	9,990	0	50.00
53.00	05300	ANESTHESIOLOGY	34,964	118	0	118	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,713,733	7,311	0	7,311	0	54.00
60.00	06000	LABORATORY	1,681,272	3,045	0	3,045	0	60.00
65.00	06500	RESPIRATORY THERAPY	293,060	377	0	377	0	65.00
66.00	06600	PHYSICAL THERAPY	1,144,470	4,398	0	4,398	0	66.00
69.00	06900	ELECTROCARDIOLOGY	68,929	524	0	524	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,862	330	0	330	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	891,330	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	986,237	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,027,563	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	14,738	0	14,738	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,500	0	1,500	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	773	0	773	0	88.02
90.00	09000	CLINIC	148,755	614	0	614	0	90.00
90.01	09001	OP CLINIC	598,923	3,029	0	3,029	0	90.01
90.02	09002	SENIOR CARE	433,874	1,600	0	1,600	0	90.02
91.00	09100	EMERGENCY	2,055,849	5,143	0	5,143	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,634,529	78,277	100	76,625	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,902	0	3,902	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,081,916	1,421,968	180,943	362,322	251,996	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.073929	17.303301	1,809.430000	4.499385	2,519.960000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,799	217,032	20,925	17,927	59,482	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004428	2.640967	209.250000	0.222621	594.820000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/23/2014 10:53 am

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (PAT DAYS)	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	12,109,366					11.00
13.00	01300	NURSING ADMINISTRATION	613,609	3,505,373				13.00
15.00	01500	PHARMACY	206,732	0	1,129,025			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	283,789	0	0	57,381,528		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,202,229	1,164,190	143	2,240,983	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	870,866	845,401	328	6,247,764	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	44	945,687	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	759,845	0	3,004	14,019,156	0	54.00
60.00	06000	LABORATORY	675,800	0	2	10,653,779	0	60.00
65.00	06500	RESPIRATORY THERAPY	204,366	0	1,419	639,961	0	65.00
66.00	06600	PHYSICAL THERAPY	709,000	0	866	6,015,440	0	66.00
69.00	06900	ELECTROCARDIOLOGY	42,824	0	0	935,461	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	109	28,169	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,253,317	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,017,255	4,198,215	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873,472	0	93,965	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	207,831	0	4,614	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	106,256	0	2,027	0	0	88.02
90.00	09000	CLINIC	84,305	0	112	196,150	0	90.00
90.01	09001	OP CLINIC	376,174	364,968	2,765	661,783	0	90.01
90.02	09002	SENIOR CARE	4,757	4,757	0	730,402	0	90.02
91.00	09100	EMERGENCY	1,152,431	1,126,057	303	4,615,261	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,374,286	3,505,373	1,126,956	57,381,528	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,735,080	0	2,069	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	236,935	1,066,723	389,442	594,820	62,433	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019566	0.304311	0.344937	0.010366	624.330000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,350	42,254	22,390	51,706	3,821	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002506	0.012054	0.019831	0.000901	38.210000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,565,245		3,565,245	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,596,876		2,596,876	0	0	50.00
53.00	05300	ANESTHESIOLOGY	55,719		55,719	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,444,298		2,444,298	0	0	54.00
60.00	06000	LABORATORY	2,273,495		2,273,495	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	382,503	0	382,503	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,590,651	0	1,590,651	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	107,377		107,377	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,789		14,789	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,158,998		1,158,998	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,222,152		1,222,152	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,667,770		1,667,770	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,980,326		5,980,326	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	467,283		467,283	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	230,913		230,913	0	0	88.02
90.00	09000	CLINIC	201,447		201,447	0	0	90.00
90.01	09001	OP CLINIC	934,469		934,469	0	0	90.01
90.02	09002	SENIOR CARE	581,656		581,656	0	0	90.02
91.00	09100	EMERGENCY	3,072,919		3,072,919	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	337,219		337,219		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,886,105	0	28,886,105	0	0	200.00
201.00		Less Observation Beds	337,219		337,219		0	201.00
202.00		Total (see instructions)	28,548,886	0	28,548,886	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | 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	1,915,013		1,915,013			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,105,854	5,141,910	6,247,764	0.415649	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	229,237	716,450	945,687	0.058919	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	490,059	13,529,097	14,019,156	0.174354	0.000000	54.00
60.00	06000	LABORATORY	589,297	10,064,482	10,653,779	0.213398	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	483,149	156,812	639,961	0.597697	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	857,188	5,158,251	6,015,439	0.264428	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	24,760	910,701	935,461	0.114785	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	633	27,536	28,169	0.525010	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,398,378	1,852,362	3,250,740	0.356534	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,595,625	406,952	2,002,577	0.610290	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,025,119	3,173,096	4,198,215	0.397257	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,143,525	5,143,525			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	330,797	330,797			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	104,936	104,936			88.02
90.00	09000	CLINIC	0	196,150	196,150	1.027005	0.000000	90.00
90.01	09001	OP CLINIC	0	661,783	661,783	1.412047	0.000000	90.01
90.02	09002	SENIOR CARE	0	730,402	730,402	0.796351	0.000000	90.02
91.00	09100	EMERGENCY	47,964	4,567,297	4,615,261	0.665817	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	167,429	158,542	325,971	1.034506	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,929,705	53,031,081	62,960,786			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,929,705	53,031,081	62,960,786			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OP CLINIC	0.000000	90.01
90.02	09002	SENIOR CARE	0.000000	90.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/23/2014 10:53 am

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	3,565,245		3,565,245	0	3,565,245	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,596,876		2,596,876	0	2,596,876	50.00
53.00	05300	ANESTHESIOLOGY	55,719		55,719	0	55,719	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,444,298		2,444,298	0	2,444,298	54.00
60.00	06000	LABORATORY	2,273,495		2,273,495	0	2,273,495	60.00
65.00	06500	RESPIRATORY THERAPY	382,503	0	382,503	0	382,503	65.00
66.00	06600	PHYSICAL THERAPY	1,590,651	0	1,590,651	0	1,590,651	66.00
69.00	06900	ELECTROCARDIOLOGY	107,377		107,377	0	107,377	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,789		14,789	0	14,789	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,158,998		1,158,998	0	1,158,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,222,152		1,222,152	0	1,222,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,667,770		1,667,770	0	1,667,770	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,980,326		5,980,326	0	5,980,326	88.00
88.01	08801	RURAL HEALTH CLINIC II	467,283		467,283	0	467,283	88.01
88.02	08802	RURAL HEALTH CLINIC III	230,913		230,913	0	230,913	88.02
90.00	09000	CLINIC	201,447		201,447	0	201,447	90.00
90.01	09001	OP CLINIC	934,469		934,469	0	934,469	90.01
90.02	09002	SENIOR CARE	581,656		581,656	0	581,656	90.02
91.00	09100	EMERGENCY	3,072,919		3,072,919	0	3,072,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	337,219		337,219		337,219	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,886,105	0	28,886,105	0	28,886,105	200.00
201.00		Less Observation Beds	337,219		337,219		337,219	201.00
202.00		Total (see instructions)	28,548,886	0	28,548,886	0	28,548,886	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/23/2014 10:53 am

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	1,915,013		1,915,013			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,105,854	5,141,910	6,247,764	0.415649	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	229,237	716,450	945,687	0.058919	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	490,059	13,529,097	14,019,156	0.174354	0.000000	54.00
60.00	06000	LABORATORY	589,297	10,064,482	10,653,779	0.213398	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	483,149	156,812	639,961	0.597697	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	857,188	5,158,251	6,015,439	0.264428	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	24,760	910,701	935,461	0.114785	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	633	27,536	28,169	0.525010	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,398,378	1,852,362	3,250,740	0.356534	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,595,625	406,952	2,002,577	0.610290	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,025,119	3,173,096	4,198,215	0.397257	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,143,525	5,143,525	1.162690	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	330,797	330,797	1.412597	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	104,936	104,936	2.200513	0.000000	88.02
90.00	09000	CLINIC	0	196,150	196,150	1.027005	0.000000	90.00
90.01	09001	OP CLINIC	0	661,783	661,783	1.412047	0.000000	90.01
90.02	09002	SENIOR CARE	0	730,402	730,402	0.796351	0.000000	90.02
91.00	09100	EMERGENCY	47,964	4,567,297	4,615,261	0.665817	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	167,429	158,542	325,971	1.034506	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,929,705	53,031,081	62,960,786			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,929,705	53,031,081	62,960,786			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/23/2014 10:53 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OP CLINIC	0.000000		90.01
90.02	09002	SENIOR CARE	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		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	246,694	6,247,764	0.039485	501,034	19,783	50.00
53.00	05300	ANESTHESIOLOGY	3,847	945,687	0.004068	103,935	423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	192,051	14,019,156	0.013699	299,696	4,106	54.00
60.00	06000	LABORATORY	104,508	10,653,779	0.009809	380,993	3,737	60.00
65.00	06500	RESPIRATORY THERAPY	14,446	639,961	0.022573	144,703	3,266	65.00
66.00	06600	PHYSICAL THERAPY	116,445	6,015,439	0.019358	209,921	4,064	66.00
69.00	06900	ELECTROCARDIOLOGY	12,602	935,461	0.013471	16,039	216	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,602	28,169	0.234371	317	74	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,176	3,250,740	0.006822	626,126	4,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,300	2,002,577	0.009638	753,077	7,258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,064	4,198,215	0.010496	539,638	5,664	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	372,955	5,143,525	0.072510	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	35,767	330,797	0.108124	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	18,294	104,936	0.174335	0	0	88.02
90.00	09000	CLINIC	15,410	196,150	0.078562	0	0	90.00
90.01	09001	OP CLINIC	77,400	661,783	0.116957	0	0	90.01
90.02	09002	SENIOR CARE	40,544	730,402	0.055509	0	0	90.02
91.00	09100	EMERGENCY	162,733	4,615,261	0.035260	128	5	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	325,971	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,505,838	61,045,773		3,575,607	52,867	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OP CLINIC	0	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		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	6,247,764	0.000000	0.000000	501,034	50.00
53.00	05300	ANESTHESIOLOGY	0	945,687	0.000000	0.000000	103,935	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,019,156	0.000000	0.000000	299,696	54.00
60.00	06000	LABORATORY	0	10,653,779	0.000000	0.000000	380,993	60.00
65.00	06500	RESPIRATORY THERAPY	0	639,961	0.000000	0.000000	144,703	65.00
66.00	06600	PHYSICAL THERAPY	0	6,015,439	0.000000	0.000000	209,921	66.00
69.00	06900	ELECTROCARDIOLOGY	0	935,461	0.000000	0.000000	16,039	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	28,169	0.000000	0.000000	317	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,250,740	0.000000	0.000000	626,126	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,002,577	0.000000	0.000000	753,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,198,215	0.000000	0.000000	539,638	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,143,525	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	330,797	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	104,936	0.000000	0.000000	0	88.02
90.00	09000	CLINIC	0	196,150	0.000000	0.000000	0	90.00
90.01	09001	OP CLINIC	0	661,783	0.000000	0.000000	0	90.01
90.02	09002	SENIOR CARE	0	730,402	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	4,615,261	0.000000	0.000000	128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	325,971	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	61,045,773			3,575,607	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OP CLINIC	0	0	0		90.01
90.02	09002	SENIOR CARE	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		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	0.415649	0	1,603,775	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.058919	0	211,762	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174354	0	4,235,895	0	0	54.00
60.00	06000	LABORATORY	0.213398	0	4,000,984	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.597697	0	51,115	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264428	0	1,663,075	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.114785	0	386,867	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525010	0	7,596	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356534	0	530,053	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.610290	0	139,112	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.397257	0	1,341,253	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.027005	0	127,549	40	0	90.00
90.01	09001	OP CLINIC	1.412047	0	214,314	0	0	90.01
90.02	09002	SENIOR CARE	0.796351	0	702,200	0	0	90.02
91.00	09100	EMERGENCY	0.665817	0	1,252,216	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.034506	0	80,439	0	0	92.00
200.00		Subtotal (see instructions)		0	16,548,205	40	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	16,548,205	40	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		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	666,607	0		50.00
53.00	05300	ANESTHESIOLOGY	12,477	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738,545	0		54.00
60.00	06000	LABORATORY	853,802	0		60.00
65.00	06500	RESPIRATORY THERAPY	30,551	0		65.00
66.00	06600	PHYSICAL THERAPY	439,764	0		66.00
69.00	06900	ELECTROCARDIOLOGY	44,407	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,988	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	188,982	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	84,899	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	532,822	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	130,993	41		90.00
90.01	09001	OP CLINIC	302,621	0		90.01
90.02	09002	SENIOR CARE	559,198	0		90.02
91.00	09100	EMERGENCY	833,747	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	83,215	0		92.00
200.00		Subtotal (see instructions)	5,506,618	41		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,506,618	41		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141320 | Component CCN: 14Z320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	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	0.415649	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.058919	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174354	0	0	0	0	54.00
60.00	06000	LABORATORY	0.213398	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.597697	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264428	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.114785	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525010	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356534	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.610290	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.397257	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.027005	0	0	0	0	90.00
90.01	09001	OP CLINIC	1.412047	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0.796351	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.665817	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.034506	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141320 | Component CCN: 14Z320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Swing Beds - SNF | Cost

		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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OP CLINIC	0	0		90.01
90.02	09002	SENIOR CARE	0	0		90.02
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)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/23/2014 10:53 am

Title XIX | Hospital | Cost

		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	0.415649	0	0	812,349	0	50.00
53.00	05300	ANESTHESIOLOGY	0.058919	0	0	119,384	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174354	0	0	2,091,597	0	54.00
60.00	06000	LABORATORY	0.213398	0	0	614,725	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.597697	0	0	9,512	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264428	0	0	1,154,234	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.114785	0	0	160,586	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525010	0	0	3,482	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356534	0	0	372,552	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.610290	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.397257	0	0	580,245	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.162690				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.412597				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2.200513				0	88.02
90.00	09000	CLINIC	1.027005	0	0	39,404	0	90.00
90.01	09001	OP CLINIC	1.412047	0	0	2,111	0	90.01
90.02	09002	SENIOR CARE	0.796351	0	0	1,074	0	90.02
91.00	09100	EMERGENCY	0.665817	0	0	466,573	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.034506	0	0	8,638	0	92.00
200.00		Subtotal (see instructions)		0	0	6,436,466	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	6,436,466	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/23/2014 10:53 am

Title XIX | Hospital | Cost

		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	337,652		50.00
53.00	05300	ANESTHESIOLOGY	0	7,034		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	364,678		54.00
60.00	06000	LABORATORY	0	131,181		60.00
65.00	06500	RESPIRATORY THERAPY	0	5,685		65.00
66.00	06600	PHYSICAL THERAPY	0	305,212		66.00
69.00	06900	ELECTROCARDIOLOGY	0	18,433		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,828		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	132,827		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	230,506		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	40,468		90.00
90.01	09001	OP CLINIC	0	2,981		90.01
90.02	09002	SENIOR CARE	0	855		90.02
91.00	09100	EMERGENCY	0	310,652		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,936		92.00
200.00		Subtotal (see instructions)	0	1,898,928		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,898,928		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,259	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,595	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,366	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	580	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	3,084	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)	945	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)	580	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,565,245	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)	362,401	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)	1,216,492	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,348,753	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,348,753	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,472.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,391,579	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,391,579	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,389,229	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,780,808	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	854,091	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)	854,091	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)	229	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,472.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	337,219	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/23/2014 10:53 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,259	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,595	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,366	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	580	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	3,084	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)	91	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,565,245	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)	362,401	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)	1,216,492	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,348,753	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,348,753	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,472.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	134,004	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)	134,004	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/23/2014 10:53 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	393,498	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	527,502	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	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)	229	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,472.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	337,219	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/23/2014 10:53 am

Title XIX | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		854,150		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.415649	501,034	208,254	50.00
53.00	05300	ANESTHESIOLOGY	0.058919	103,935	6,124	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174354	299,696	52,253	54.00
60.00	06000	LABORATORY	0.213398	380,993	81,303	60.00
65.00	06500	RESPIRATORY THERAPY	0.597697	144,703	86,489	65.00
66.00	06600	PHYSICAL THERAPY	0.264428	209,921	55,509	66.00
69.00	06900	ELECTROCARDIOLOGY	0.114785	16,039	1,841	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525010	317	166	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356534	626,126	223,235	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.610290	753,077	459,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.397257	539,638	214,375	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.027005	0	0	90.00
90.01	09001	OP CLINIC	1.412047	0	0	90.01
90.02	09002	SENIOR CARE	0.796351	0	0	90.02
91.00	09100	EMERGENCY	0.665817	128	85	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.034506	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,575,607	1,389,229	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,575,607		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141320 | Component CCN: 14Z320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.415649	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.058919	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174354	33,872	5,906	54.00
60.00	06000	LABORATORY	0.213398	25,739	5,493	60.00
65.00	06500	RESPIRATORY THERAPY	0.597697	55,890	33,405	65.00
66.00	06600	PHYSICAL THERAPY	0.264428	396,998	104,977	66.00
69.00	06900	ELECTROCARDIOLOGY	0.114785	933	107	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525010	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356534	34,007	12,125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.610290	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.397257	128,375	50,998	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.027005	0	0	90.00
90.01	09001	OP CLINIC	1.412047	0	0	90.01
90.02	09002	SENIOR CARE	0.796351	0	0	90.02
91.00	09100	EMERGENCY	0.665817	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.034506	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		675,814	213,011	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)		675,814		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/23/2014 10:53 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.415649	216,546	90,007	50.00
53.00	05300	ANESTHESIOLOGY	0.058919	44,695	2,633	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174354	34,932	6,091	54.00
60.00	06000	LABORATORY	0.213398	47,529	10,143	60.00
65.00	06500	RESPIRATORY THERAPY	0.597697	37,567	22,454	65.00
66.00	06600	PHYSICAL THERAPY	0.264428	83,998	22,211	66.00
69.00	06900	ELECTROCARDIOLOGY	0.114785	1,679	193	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525010	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356534	505,233	180,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.610290	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.397257	114,109	45,331	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.162690	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.412597	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2.200513	0	0	88.02
90.00	09000	CLINIC	1.027005	0	0	90.00
90.01	09001	OP CLINIC	1.412047	0	0	90.01
90.02	09002	SENIOR CARE	0.796351	0	0	90.02
91.00	09100	EMERGENCY	0.665817	8,059	5,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.034506	8,638	8,936	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,102,985	393,498	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,102,985		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141320	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/23/2014 10:53 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,506,659	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,506,659	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,561,726	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	50,162	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,492,802	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,018,762	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,018,762	30.00
31.00	Primary payer payments	2,117	31.00
32.00	Subtotal (line 30 minus line 31)	3,016,645	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)	761,406	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	670,037	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,686,682	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)	3,686,682	40.00
40.01	Sequestration adjustment (see instructions)	55,669	40.01
41.00	Interim payments	3,333,367	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	297,646	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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,692,845		2,708,485	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		70,438		671,412	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	07/10/2013	215,148		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	07/10/2013	46,530	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)		215,148		-46,530	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,978,431		3,333,367	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		569,406		297,646	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,547,837		3,631,013	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: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2014 10:53 am

Component CCN: 14Z320 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		951,229		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	07/10/2013	63,983		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)		63,983		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,015,212		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		40,748		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,055,960		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: 141320	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/23/2014 10:53 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	470	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	945	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	23	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,366	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	62,960,786	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	3,433,479	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	514,941	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	488,782	8.00
9.00	Sequestration adjustment amount (see instructions)	9,776	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	479,006	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	479,006	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141320 | Component CCN: 14Z320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-2 | Date/Time Prepared: 5/23/2014 10:53 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	862,632	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)	215,141	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	580	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,077,773	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,077,773	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,077,773	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,624	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,072,149	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)	1,072,149	0	19.00
19.01	Sequestration adjustment (see instructions)	16,189	0	19.01
20.00	Interim payments	1,015,212	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	40,748	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141320	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/23/2014 10:53 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,780,808	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,780,808	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,808,616	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,808,616	19.00
20.00	Deductibles (exclude professional component)	258,035	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,550,581	22.00
23.00	Coinsurance	1,480	23.00
24.00	Subtotal (line 22 minus line 23)	2,549,101	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42,952	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	37,798	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,586,899	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,586,899	30.00
30.01	Sequestration adjustment (see instructions)	39,062	30.01
31.00	Interim payments	1,978,431	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	569,406	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	372,413	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G | Date/Time Prepared: 5/23/2014 10:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,102,277	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	16,042,772	0	0	0	4.00
5.00	Other receivable	1,325,502	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,824,951	0	0	0	6.00
7.00	Inventory	940,837	0	0	0	7.00
8.00	Prepaid expenses	406,422	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,992,859	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,541,920	0	0	0	15.00
16.00	Accumulated depreciation	-22,689,841	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,852,079	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	16,511,815	0	0	0	33.00
34.00	Other assets	150,803	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,662,618	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,507,556	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,215,311	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	1,428,551	0	0	0	39.00
40.00	Notes and loans payable (short term)	674,658	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	272,450	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,590,970	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	3,660,985	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	3,660,985	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	7,251,955	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,255,601				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)	39,255,601	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,507,556	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-1 | Date/Time Prepared: 5/23/2014 10:53 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		35,821,914		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,277,461				2.00
3.00	Total (sum of line 1 and line 2)		38,099,375		0		3.00
4.00	MISCELLANEOUS	1,093,357		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)		1,093,357		0		10.00
11.00	Subtotal (line 3 plus line 10)		39,192,732		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39,192,732		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	MISCELLANEOUS		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	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/23/2014 10:53 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,400,859		1,400,859	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	840,124		840,124	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,240,983		2,240,983	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,240,983		2,240,983	17.00
18.00	Ancillary services	7,847,265	45,704,945	53,552,210	18.00
19.00	Outpatient services	0	1,588,334	1,588,334	19.00
20.00	RURAL HEALTH CLINIC	0	4,582,178	4,582,178	20.00
20.01	RURAL HEALTH CLINIC II	0	331,043	331,043	20.01
20.02	RURAL HEALTH CLINIC III	0	105,063	105,063	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	PRO FEES	1,270,065	13,641,944	14,912,009	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,358,313	65,953,507	77,311,820	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,201,906		29.00
30.00		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)		37,201,906		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-3 | Date/Time Prepared: 5/23/2014 10:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,311,820	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,179,951	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,131,869	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,201,906	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,070,037	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 OPERATING REVENUE	1,190,239	24.00
24.01	NON-OPERATING INCOME	3,157,259	24.01
25.00	Total other income (sum of lines 6-24)	4,347,498	25.00
26.00	Total (line 5 plus line 25)	2,277,461	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,277,461	29.00

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

Provider CCN: 141320 Component CCN: 143987 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/23/2014 10:53 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,305,275	0	1,305,275	0	1,305,275	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	264,994	0	264,994	0	264,994	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	631,048	0	631,048	0	631,048	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)	2,201,317	0	2,201,317	0	2,201,317	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	2,826	2,826	0	2,826	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	72,864	72,864	0	72,864	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	75,690	75,690	0	75,690	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,201,317	75,690	2,277,007	0	2,277,007	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	106,303	106,303	0	106,303	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	242,522	242,522	0	242,522	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	348,825	348,825	0	348,825	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	675,734	641,327	1,317,061	-20,900	1,296,161	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	675,734	641,327	1,317,061	-20,900	1,296,161	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,877,051	1,065,842	3,942,893	-20,900	3,921,993	32.00

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

Provider CCN: 141320 | Component CCN: 143987 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/23/2014 10:53 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,305,275		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	264,994		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	631,048		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	2,201,317		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	2,826		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	72,864		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	75,690		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,277,007		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	106,303		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	242,522		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	348,825		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-144,055	1,152,106		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-144,055	1,152,106		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-144,055	3,777,938		32.00

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

Provider CCN: 141320 Component CCN: 143989 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/23/2014 10:53 am

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	16,962	0	16,962	0	16,962	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	84,686	0	84,686	0	84,686	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	52,629	0	52,629	0	52,629	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)	154,277	0	154,277	0	154,277	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	121	121	0	121	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	121	121	0	121	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	154,277	121	154,398	0	154,398	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	5,051	5,051	0	5,051	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	19,755	19,755	0	19,755	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	24,806	24,806	0	24,806	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	52,648	89,640	142,288	-29,704	112,584	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,648	89,640	142,288	-29,704	112,584	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	206,925	114,567	321,492	-29,704	291,788	32.00

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

Provider CCN: 141320 | Component CCN: 143989 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/23/2014 10:53 am

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	16,962		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	84,686		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	52,629		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	154,277		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	121		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	121		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	154,398		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	5,051		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	19,755		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	24,806		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-3,455	109,129		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,455	109,129		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,455	288,333		32.00

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

Provider CCN: 141320 Component CCN: 143431 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/23/2014 10:53 am

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	10,662	0	10,662	0	10,662	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	56,573	0	56,573	0	56,573	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	25,385	0	25,385	0	25,385	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)	92,620	0	92,620	0	92,620	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	53	53	0	53	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	615	615	0	615	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	668	668	0	668	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	92,620	668	93,288	0	93,288	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	2,219	2,219	0	2,219	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	8,815	8,815	0	8,815	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	11,034	11,034	0	11,034	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	13,405	40,032	53,437	-16,384	37,053	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	13,405	40,032	53,437	-16,384	37,053	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	106,025	51,734	157,759	-16,384	141,375	32.00

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

Provider CCN: 141320 | Component CCN: 143431 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/23/2014 10:53 am

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	10,662		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	56,573		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	25,385		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	92,620		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	53		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	615		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	668		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	93,288		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	2,219		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	8,815		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	11,034		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-936	36,117		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-936	36,117		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-936	140,439		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141320 | Component CCN: 143987 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2 | Date/Time Prepared: 5/23/2014 10:53 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.61	25,193	4,200	15,162		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.09	8,059	2,100	4,389		3.00
4.00	Subtotal (sum of lines 1-3)	5.70	33,252		19,551	33,252	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)	5.70	33,252			33,252	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)					2,277,007	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					348,825	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,625,832	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.867156	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					1,152,106	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,202,388	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,354,494	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					3,354,494	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,908,870	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					5,185,877	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141320 | Component CCN: 143989 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2 | Date/Time Prepared: 5/23/2014 10:53 am

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	0.01	0	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.81	2,464	2,100	1,701		3.00
4.00	Subtotal (sum of lines 1-3)	0.82	2,464		1,743	2,464	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)	0.82	2,464			2,464	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)					154,398	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					24,806	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					179,204	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.861577	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					109,129	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					178,950	15.00
16.00	Total overhead (sum of lines 14 and 15)					288,079	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					288,079	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					248,202	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					402,600	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141320 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2

Component CCN: 143431 | Date/Time Prepared: 5/23/2014 10:53 am

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	0.01	0	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.51	625	2,100	1,071		3.00
4.00	Subtotal (sum of lines 1-3)	0.52	625		1,113	1,113	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	625			1,113	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)					93,288	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					11,034	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					104,322	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.894231	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					36,117	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					90,474	15.00
16.00	Total overhead (sum of lines 14 and 15)					126,591	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					126,591	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					113,202	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					206,490	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3 Date/Time Prepared: 5/23/2014 10:53 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		5,185,877	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		53,031	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		5,132,846	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		33,252	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)		33,252	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		154.36	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)	78.54	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	154.36	154.36	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	8,186	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,263,591	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,263,591	16.00
16.01	Total program charges (see instructions)(from contractor's records)		829,788	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.)		916,069	16.04
16.05	Total program cost (see instructions)		916,069	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		118,505	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		142,071	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		916,069	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		21,875	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		937,944	22.00
23.00	Allowable bad debts (see instructions)		65,438	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		57,585	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)		995,529	26.00
26.01	Sequestration adjustment (see instructions)		15,032	26.01
27.00	Interim payments		853,594	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		126,903	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: 141320 Component CCN: 143989	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3 Date/Time Prepared: 5/23/2014 10:53 am
	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)		402,600	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		2,502	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		400,098	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,464	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)		2,464	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		162.38	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)	78.54	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	162.38	162.38	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	364	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	59,106	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		59,106	16.00
16.01	Total program charges (see instructions)(from contractor's records)		35,685	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.)		42,147	16.04
16.05	Total program cost (see instructions)		42,147	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,422	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,852	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		42,147	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,724	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		43,871	22.00
23.00	Allowable bad debts (see instructions)		1,321	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,162	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)		45,033	26.00
26.01	Sequestration adjustment (see instructions)		680	26.01
27.00	Interim payments		45,884	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		-1,531	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: 141320 | Component CCN: 143431 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-3 | Date/Time Prepared: 5/23/2014 10:53 am

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)		206,490	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		898	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		205,592	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,113	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)		1,113	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		184.72	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)	78.54	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	184.72	184.72	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	108	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	19,950	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) *		19,950	16.00
16.01	Total program charges (see instructions)(from contractor's records)		10,425	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.)		14,477	16.04
16.05	Total program cost (see instructions)		14,477	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,854	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,714	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		14,477	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		449	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		14,926	22.00
23.00	Allowable bad debts (see instructions)		693	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		610	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)		15,536	26.00
26.01	Sequestration adjustment (see instructions)		235	26.01
27.00	Interim payments		14,879	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		422	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: 141320 Component CCN: 143987	Period: From 01/01/2013 To 12/31/2013	Worksheet M-4 Date/Time Prepared: 5/23/2014 10:53 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	2,201,317	2,201,317	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,836	16,606	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,836	16,606	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	2,277,007	2,277,007	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	3,354,494	3,354,494	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002124	0.007293	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,125	24,464	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	11,961	41,070	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	73	1,132	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	163.85	36.28	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	27	481	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,424	17,451	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)		53,031	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)		21,875	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2013 To 12/31/2013	Worksheet M-4 Date/Time Prepared: 5/23/2014 10:53 am
	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)	154,277	154,277	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	66	807	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	66	807	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	154,398	154,398	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	288,079	288,079	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000427	0.005227	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	123	1,506	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	189	2,313	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	55	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	189.00	42.05	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	41	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	1,724	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)		2,502	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)		1,724	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2013 To 12/31/2013	Worksheet M-4 Date/Time Prepared: 5/23/2014 10:53 am
	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)	92,620	92,620	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	381	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	381	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	93,288	93,288	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	126,591	126,591	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.004084	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	517	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	898	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	26	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	34.54	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	13	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	449	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)		898	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)		449	16.00

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

Provider CCN: 141320 | Component CCN: 143987 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 5/23/2014 10:53 am

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		818,845	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		07/10/2013	34,749	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)		34,749	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		853,594	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		126,903	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		980,497	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: 141320 | Component CCN: 143989 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 5/23/2014 10:53 am

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		45,884	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)		45,884	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,531	6.02
7.00	Total Medicare program liability (see instructions)		44,353	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: 141320 | Component CCN: 143431 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 5/23/2014 10:53 am

Rural Health Clinic (RHC) III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		14,879	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)		14,879	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		422	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		15,301	7.00

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