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: 141327	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/20/2014 2:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/20/2014 Time: 2:58 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH GENERAL HOSPITAL (141327) 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	252,717	129,422	11,484	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	-16,395	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		1,983		0	10.00
200.00	Total	0	236,322	131,405	11,484	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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/20/2014 2:57 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863-	County: WABASH	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	WABASH GENERAL HOSPITAL	141327	14999	1	06/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	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	WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2013	12/31/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/20/2014 2:57 pm

		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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/20/2014 2:57 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/20/2014 2:57 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
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
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

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		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

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

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

		1.00	
	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)	12,800	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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/20/2014 2:57 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/15/2013	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	04/16/2014	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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/20/2014 2:57 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				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.	RICH	FERRIELL	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.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/20/2014 2:57 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/16/2014			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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 5/20/2014 2:57 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	54,320.00	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)		21	7,665	54,320.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	2,152.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	56,472.00	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
26.25	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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/20/2014 2:57 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,809	98	2,549			1.00
2.00	HMO and other (see instructions)	27	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	386	0	386			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		37	37			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,195	135	2,972			7.00
8.00	INTENSIVE CARE UNIT	50	51	101			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)	2,245	186	3,073	0.00	213.96	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	276	0	4,654	0.00	1.95	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	215.91	27.00
28.00	Observation Bed Days		0	631			28.00
29.00	Ambulance Trips	780					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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/20/2014 2:57 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	466	40	653	1.00
2.00	HMO and other (see instructions)			6			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	466	40	653	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
26.25	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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part IV Date/Time Prepared: 5/20/2014 2:57 pm

		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)	319,237	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	1,978,933	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	165,484	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	876,545	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	1,285	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,341,484	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: 141327 Component CCN: 148501 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 5/20/2014 2:57 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1418 COLLEGE DRIVE	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	MT.CARMEL IL	62863 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	12:00	21:00	18:00	21:00	18:00 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: 141327
Component CCN: 148501

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

Worksheet S-8
Date/Time Prepared: 5/20/2014 2:57 pm

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		WABASH				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	21:00	18:00	21:00	18:00	21:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	18:00	21:00	12:00	21:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-10 | Date/Time Prepared: 5/20/2014 2:57 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.425353	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,829,676	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	127,482	5.00
6.00	Medicaid charges	8,982,387	6.00
7.00	Medicaid cost (line 1 times line 6)	3,820,685	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,863,527	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)	1,863,527	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	310,691	0	310,691	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	132,153	0	132,153	21.00
22.00	Partial payment by patients approved for charity care	0	12,665	12,665	22.00
23.00	Cost of charity care (line 21 minus line 22)	132,153	-12,665	119,488	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)	4,773,828	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	114,795	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,659,033	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,981,734	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,101,222	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,964,749	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		603,172	603,172	0	603,172	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		708,353	708,353	701,531	1,409,884	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	133,309	3,749,934	3,883,243	0	3,883,243	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,094,843	2,867,828	3,962,671	122,411	4,085,082	5.00
7.00	00700	OPERATION OF PLANT	171,610	749,512	921,122	29,686	950,808	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	228,500	45,805	274,305	108,022	382,327	9.00
10.00	01000	DIETARY	345,933	211,063	556,996	-381,784	175,212	10.00
11.00	01100	CAFETERIA	0	0	0	380,672	380,672	11.00
13.00	01300	NURSING ADMINISTRATION	210,496	18,223	228,719	0	228,719	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	334,380	66,851	401,231	0	401,231	16.00
17.00	01700	SOCIAL SERVICE	135,537	8,581	144,118	0	144,118	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	789,470	42,742	832,212	-5,869	826,343	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,227,751	358,521	1,586,272	-55,926	1,530,346	30.00
31.00	03100	INTENSIVE CARE UNIT	265,351	3,023	268,374	-2,218	266,156	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	611,941	321,373	933,314	-78,116	855,198	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	620,025	923,963	1,543,988	-102,502	1,441,486	54.00
60.00	06000	LABORATORY	659,677	608,702	1,268,379	-62,515	1,205,864	60.00
65.00	06500	RESPIRATORY THERAPY	470,625	163,422	634,047	-26,791	607,256	65.00
66.00	06600	PHYSICAL THERAPY	656,791	68,688	725,479	-1,482	723,997	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,607	2,427,176	2,533,783	-1,615,533	918,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,782,023	1,782,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	347,255	1,174,679	1,521,934	3,160	1,525,094	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	170,930	25,931	196,861	-1,038	195,823	88.00
90.00	09000	CLINIC	164,018	159,825	323,843	-514	323,329	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,029,705	180,975	2,210,680	-39,788	2,170,892	90.01
90.02	09002	SURGICAL CLINIC	812,340	164,085	976,425	-39,893	936,532	90.02
90.03	09003	OP CLINIC	11,728	910	12,638	0	12,638	90.03
91.00	09100	EMERGENCY	964,723	1,534,523	2,499,246	-181,724	2,317,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	561,715	120,156	681,871	-17,639	664,232	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		346,070	346,070	-346,070	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,125,260	17,654,086	30,779,346	168,103	30,947,449	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	448,197	633,237	1,081,434	-168,103	913,331	192.00
200.00		TOTAL (SUM OF LINES 118-199)	13,573,457	18,287,323	31,860,780	0	31,860,780	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	603,172		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-250,191	1,159,693		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-870,837	3,012,406		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-301,158	3,783,924		5.00
7.00	00700	OPERATION OF PLANT	0	950,808		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	382,327		9.00
10.00	01000	DIETARY	-10,354	164,858		10.00
11.00	01100	CAFETERIA	-83,335	297,337		11.00
13.00	01300	NURSING ADMINISTRATION	0	228,719		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-21,021	380,210		16.00
17.00	01700	SOCIAL SERVICE	0	144,118		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-789,470	36,873		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-235,000	1,295,346		30.00
31.00	03100	INTENSIVE CARE UNIT	0	266,156		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	855,198		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,655	1,436,831		54.00
60.00	06000	LABORATORY	-51,323	1,154,541		60.00
65.00	06500	RESPIRATORY THERAPY	-97,264	509,992		65.00
66.00	06600	PHYSICAL THERAPY	0	723,997		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-902	917,348		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,782,023		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-22,951	1,502,143		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	195,823		88.00
90.00	09000	CLINIC	-114,400	208,929		90.00
90.01	09001	ORTHOPAEDIC CLINIC	-1,467,974	702,918		90.01
90.02	09002	SURGICAL CLINIC	-660,764	275,768		90.02
90.03	09003	OP CLINIC	0	12,638		90.03
91.00	09100	EMERGENCY	-888,984	1,428,538		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	664,232		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,870,583	25,076,866		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	913,331		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-5,870,583	25,990,197		200.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/20/2014 2:57 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	286,130	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	286,130	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	236,424	144,248	1.00
	TOTALS		236,424	144,248	
	C - IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,116	1.00
	TOTALS		0	5,116	
	D - MATERIALS MANAGEMENT				
1.00	ADMINISTRATIVE & GENERAL	5.00	54,156	0	1.00
	TOTALS		54,156	0	
	E - INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	346,070	1.00
	TOTALS		0	346,070	
	F - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,586	1.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	5,586	
	G - MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	220,176	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	220,176	
	H - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	29,686	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	29,686	
	I - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,782,023	1.00
	TOTALS		0	1,782,023	
	J - LINEN				
1.00	HOUSEKEEPING	9.00	0	108,022	1.00
	TOTALS		0	108,022	
	L - INSURANCE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	69,331	1.00
	TOTALS		0	69,331	
	M - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	140,034	1.00
	TOTALS		0	140,034	
500.00	Grand Total: Increases		290,580	3,136,422	500.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/20/2014 2:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,448	9		1.00
2.00	DIETARY	10.00	0	1,112	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,916	0		3.00
4.00	OPERATING ROOM	50.00	0	34,299	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	93,797	0		5.00
6.00	LABORATORY	60.00	0	31,134	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	7,380	0		7.00
9.00	ORTHOPAEDIC CLINIC	90.01	0	30,756	0		9.00
10.00	SURGICAL CLINIC	90.02	0	32,832	0		10.00
11.00	AMBULANCE SERVICES	95.00	0	12,000	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	37,456	0		12.00
	TOTALS		0	286,130			
	B - CAFETERIA						
1.00	DIETARY	10.00	236,424	144,248	0		1.00
	TOTALS		236,424	144,248			
	C - IV SOLUTIONS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,116	0		1.00
	TOTALS		0	5,116			
	D - MATERIALS MANAGEMENT						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	54,156	0	0		1.00
	TOTALS		54,156	0			
	E - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	346,070	9		1.00
	TOTALS		0	346,070			
	F - OXYGEN						
1.00		0.00	0	0	0		1.00
3.00	RESPIRATORY THERAPY	65.00	0	4,846	0		3.00
4.00	AMBULANCE SERVICES	95.00	0	740	0		4.00
	TOTALS		0	5,586			
	G - MED SUPPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	5,869	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	53,010	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	2,218	0		3.00
4.00	OPERATING ROOM	50.00	0	43,817	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,705	0		5.00
6.00	LABORATORY	60.00	0	31,381	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	14,565	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	1,482	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,956	0		9.00
10.00	CLINIC	90.00	0	514	0		10.00
11.00	ORTHOPAEDIC CLINIC	90.01	0	9,032	0		11.00
12.00	EMERGENCY	91.00	0	41,690	0		12.00
13.00	RURAL HEALTH CLINIC	88.00	0	1,038	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	4,899	0		14.00
	TOTALS		0	220,176			
	H - UTILITIES						
1.00	SURGICAL CLINIC	90.02	0	7,061	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	22,625	0		2.00
	TOTALS		0	29,686			
	I - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,782,023	0		1.00
	TOTALS		0	1,782,023			
	J - LINEN						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	108,022	0		1.00
	TOTALS		0	108,022			
	L - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	69,331	9		1.00
	TOTALS		0	69,331			
	M - MALPRACTICE						
1.00	EMERGENCY	91.00	0	140,034	0		1.00
	TOTALS		0	140,034			
500.00	Grand Total: Decreases		290,580	3,136,422			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 5/20/2014 2:57 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	416,867	0	0	0	0	1.00
2.00	Land Improvements	1,234,952	248,810	0	248,810	0	2.00
3.00	Buildings and Fixtures	16,298,649	113,325	0	113,325	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,639,500	0	0	0	0	5.00
6.00	Movable Equipment	10,189,052	539,723	0	539,723	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,779,020	901,858	0	901,858	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,779,020	901,858	0	901,858	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	416,867	0	1.00
2.00	Land Improvements	1,483,762	0	2.00
3.00	Buildings and Fixtures	16,411,974	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,639,500	0	5.00
6.00	Movable Equipment	10,728,775	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,680,878	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,680,878	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 5/20/2014 2:57 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	603,172	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	708,353	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,311,525	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	603,172		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	708,353		2.00
3.00	Total (sum of lines 1-2)	0	1,311,525		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 5/20/2014 2:57 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1	0	1	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	603,172	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,159,693	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,762,865	0	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	603,172	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,159,693	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,762,865	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/20/2014 2:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-63,031	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)	B	-11,415	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-3,519,356			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,008			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-83,335	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-902	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-22,951	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-21,021	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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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	A	-187,160	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/20/2014 2:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	DIETARY	B	-10,354	DIETARY	10.00	0	33.00
35.00	MISCELLANEOUS	B	-20,126	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PHYSICIAN RECRUITMENT	A	-269,617	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PUBLIC RELATIONS	A	-273,837	EMPLOYEE BENEFITS	4.00	0	37.00
39.00	CRNA SALARY	A	-789,470	NONPHYSICIAN ANESTHETISTS	19.00	0	39.00
40.00	CRNA EMP BEN	A	-194,172	EMPLOYEE BENEFITS	4.00	0	40.00
42.00	EMPLOYEE DISCOUNT	A	120,741	EMPLOYEE BENEFITS	4.00	0	42.00
43.00	ORTHO EMP BEN	A	-361,052	EMPLOYEE BENEFITS	4.00	0	43.00
44.00	SURGEONS EMP BEN	A	-162,517	EMPLOYEE BENEFITS	4.00	0	44.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,870,583				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141327	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-1 Date/Time Prepared: 5/20/2014 2:57 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	233,670	234,678	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		0	233,670	234,678	5.00

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

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

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

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

6.00	A	DSS MRI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141327	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-1 Date/Time Prepared: 5/20/2014 2:57 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-1,008	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,008			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 5/20/2014 2:57 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	235,000	235,000	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	3,647	3,647	0	0	0	2.00
3.00	60.00	LABORATORY	51,323	51,323	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	97,264	97,264	0	0	0	4.00
5.00	90.00	CLINIC	114,400	114,400	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	1,467,974	1,467,974	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	660,764	660,764	0	0	0	7.00
8.00	91.00	EMERGENCY	1,305,664	888,984	416,680	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,936,036	3,519,356	416,680		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	30.00	ADULTS & PEDIATRICS	0	0	0	235,000		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,647		2.00
3.00	60.00	LABORATORY	0	0	0	51,323		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	97,264		4.00
5.00	90.00	CLINIC	0	0	0	114,400		5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	1,467,974		6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	660,764		7.00
8.00	91.00	EMERGENCY	0	0	0	888,984		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,519,356		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/20/2014 2:57 pm

		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	603,172	603,172				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,159,693		1,159,693			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,012,406	1,314	2,527	3,016,247		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,783,924	39,698	76,325	329,376	4,229,323	5.00
7.00	00700	OPERATION OF PLANT	950,808	23,550	45,279	49,194	1,068,831	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	382,327	5,897	11,337	65,502	465,063	9.00
10.00	01000	DIETARY	164,858	37,461	72,026	29,509	303,854	10.00
11.00	01100	CAFETERIA	297,337	0	0	69,657	366,994	11.00
13.00	01300	NURSING ADMINISTRATION	228,719	2,830	5,441	60,341	297,331	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	380,210	10,643	20,463	95,854	507,170	16.00
17.00	01700	SOCIAL SERVICE	144,118	3,514	6,757	38,853	193,242	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	36,873	0	0	0	36,873	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,295,346	92,149	177,169	351,951	1,916,615	30.00
31.00	03100	INTENSIVE CARE UNIT	266,156	23,094	44,402	76,066	409,718	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	855,198	63,695	122,465	175,421	1,216,779	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,436,831	44,618	85,785	177,738	1,744,972	54.00
60.00	06000	LABORATORY	1,154,541	9,201	17,690	189,105	1,370,537	60.00
65.00	06500	RESPIRATORY THERAPY	509,992	10,132	19,481	134,911	674,516	65.00
66.00	06600	PHYSICAL THERAPY	723,997	63,093	121,306	188,278	1,096,674	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	917,348	12,104	23,271	15,035	967,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,782,023	0	0	0	1,782,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,502,143	4,619	8,880	99,545	1,615,187	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	195,823	9,146	17,585	48,999	271,553	88.00
90.00	09000	CLINIC	208,929	12,186	23,429	47,018	291,562	90.00
90.01	09001	ORTHOPAEDIC CLINIC	702,918	65,722	126,361	161,027	1,056,028	90.01
90.02	09002	SURGICAL CLINIC	275,768	0	0	43,451	319,219	90.02
90.03	09003	OP CLINIC	12,638	0	0	3,362	16,000	90.03
91.00	09100	EMERGENCY	1,428,538	29,967	57,617	276,550	1,792,672	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	664,232	32,569	62,619	161,023	920,443	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,076,866	597,202	1,148,215	2,887,766	24,930,937	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,337	4,493	0	6,830	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	913,331	3,633	6,985	128,481	1,052,430	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)	25,990,197	603,172	1,159,693	3,016,247	25,990,197	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,229,323					5.00
7.00	00700	OPERATION OF PLANT	207,732	1,276,563				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	90,387	13,976	0	569,426		9.00
10.00	01000	DIETARY	59,055	88,788	0	10,096	461,793	10.00
11.00	01100	CAFETERIA	71,327	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	57,787	6,707	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,571	25,226	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	37,557	8,329	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,166	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	372,514	218,400	0	255,174	446,615	30.00
31.00	03100	INTENSIVE CARE UNIT	79,630	54,735	0	0	15,178	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	236,486	150,965	0	105,174	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,142	105,749	0	37,558	0	54.00
60.00	06000	LABORATORY	266,369	21,808	0	2,221	0	60.00
65.00	06500	RESPIRATORY THERAPY	131,095	24,014	0	4,990	0	65.00
66.00	06600	PHYSICAL THERAPY	213,143	149,537	0	47,193	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	188,088	28,687	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	346,343	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	313,918	10,947	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	52,777	21,678	0	0	0	88.00
90.00	09000	CLINIC	56,666	28,882	0	1,154	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	205,243	155,768	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	62,041	0	0	0	0	90.02
90.03	09003	OP CLINIC	3,110	0	0	0	0	90.03
91.00	09100	EMERGENCY	348,413	71,026	0	105,029	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	178,892	77,192	0	837	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,023,452	1,262,414	0	569,426	461,793	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,327	5,538	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	204,544	8,611	0	0	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)	4,229,323	1,276,563	0	569,426	461,793	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	438,321					11.00
13.00	01300	NURSING ADMINISTRATION	5,679	367,504				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,926	0	654,893			16.00
17.00	01700	SOCIAL SERVICE	6,185	0	0	245,313		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,563	0	0	0	51,602	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,487	169,238	98,662	237,250	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,584	27,813	0	8,063	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,071	69,801	76,675	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	51,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,059	0	163,826	0	0	54.00
60.00	06000	LABORATORY	33,036	0	77,445	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,223	0	32,078	0	0	65.00
66.00	06600	PHYSICAL THERAPY	27,750	0	3,208	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,121	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	9,869	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,483	0	14,435	0	0	88.00
90.00	09000	CLINIC	8,856	0	64,458	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	49,568	0	605	0	0	90.01
90.02	09002	SURGICAL CLINIC	15,182	0	0	0	0	90.02
90.03	09003	OP CLINIC	590	0	6,416	0	0	90.03
91.00	09100	EMERGENCY	41,920	100,652	112,273	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	37,169	0	4,812	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	438,321	367,504	654,893	245,313	51,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	438,321	367,504	654,893	245,313	51,602	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,784,955	0	3,784,955		30.00
31.00	03100	INTENSIVE CARE UNIT	606,721	0	606,721		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,884,951	0	1,884,951		50.00
53.00	05300	ANESTHESIOLOGY	51,602	0	51,602		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,419,306	0	2,419,306		54.00
60.00	06000	LABORATORY	1,771,416	0	1,771,416		60.00
65.00	06500	RESPIRATORY THERAPY	889,916	0	889,916		65.00
66.00	06600	PHYSICAL THERAPY	1,537,505	0	1,537,505		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,187,654	0	1,187,654		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,128,366	0	2,128,366		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,949,921	0	1,949,921		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	365,926	0	365,926		88.00
90.00	09000	CLINIC	451,578	0	451,578		90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,467,212	0	1,467,212		90.01
90.02	09002	SURGICAL CLINIC	396,442	0	396,442		90.02
90.03	09003	OP CLINIC	26,116	0	26,116		90.03
91.00	09100	EMERGENCY	2,571,985	0	2,571,985		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,219,345	0	1,219,345		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,710,917	0	24,710,917		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,695	0	13,695		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,265,585	0	1,265,585		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	25,990,197	0	25,990,197		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,314	2,527	3,841	3,841	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	39,698	76,325	116,023	419	5.00
7.00	00700	OPERATION OF PLANT	0	23,550	45,279	68,829	63	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,897	11,337	17,234	83	9.00
10.00	01000	DIETARY	0	37,461	72,026	109,487	38	10.00
11.00	01100	CAFETERIA	0	0	0	0	89	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,830	5,441	8,271	77	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,643	20,463	31,106	122	16.00
17.00	01700	SOCIAL SERVICE	0	3,514	6,757	10,271	49	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	92,149	177,169	269,318	449	30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,094	44,402	67,496	97	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	63,695	122,465	186,160	223	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,618	85,785	130,403	226	54.00
60.00	06000	LABORATORY	0	9,201	17,690	26,891	241	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,132	19,481	29,613	172	65.00
66.00	06600	PHYSICAL THERAPY	0	63,093	121,306	184,399	240	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,104	23,271	35,375	19	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	4,619	8,880	13,499	127	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,146	17,585	26,731	62	88.00
90.00	09000	CLINIC	0	12,186	23,429	35,615	60	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	65,722	126,361	192,083	205	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	55	90.02
90.03	09003	OP CLINIC	0	0	0	0	4	90.03
91.00	09100	EMERGENCY	0	29,967	57,617	87,584	352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	32,569	62,619	95,188	205	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	597,202	1,148,215	1,745,417	3,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,337	4,493	6,830	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,633	6,985	10,618	164	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	603,172	1,159,693	1,762,865	3,841	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	116,442					5.00
7.00	00700	OPERATION OF PLANT	5,719	74,611				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	2,489	817	0	20,623		9.00
10.00	01000	DIETARY	1,626	5,189	0	366	116,706	10.00
11.00	01100	CAFETERIA	1,964	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,591	392	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,714	1,474	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,034	487	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	197	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,255	12,764	0	9,242	112,870	30.00
31.00	03100	INTENSIVE CARE UNIT	2,192	3,199	0	0	3,836	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,511	8,823	0	3,809	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,337	6,181	0	1,360	0	54.00
60.00	06000	LABORATORY	7,334	1,275	0	80	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,609	1,404	0	181	0	65.00
66.00	06600	PHYSICAL THERAPY	5,868	8,740	0	1,709	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,178	1,677	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,536	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,643	640	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,453	1,267	0	0	0	88.00
90.00	09000	CLINIC	1,560	1,688	0	42	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	5,651	9,104	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	1,708	0	0	0	0	90.02
90.03	09003	OP CLINIC	86	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,593	4,151	0	3,804	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,925	4,512	0	30	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	110,773	73,784	0	20,623	116,706	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37	324	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,632	503	0	0	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)	116,442	74,611	0	20,623	116,706	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	2,053					11.00
13.00	01300	NURSING ADMINISTRATION	27	10,358				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112	0	35,528			16.00
17.00	01700	SOCIAL SERVICE	29	0	0	11,870		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	35	0	0	0	232	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	331	4,770	5,352	11,480		30.00
31.00	03100	INTENSIVE CARE UNIT	54	784	0	390		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	136	1,967	4,160	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	131	0	8,888	0		54.00
60.00	06000	LABORATORY	155	0	4,201	0		60.00
65.00	06500	RESPIRATORY THERAPY	109	0	1,740	0		65.00
66.00	06600	PHYSICAL THERAPY	130	0	174	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26	0	783	0		88.00
90.00	09000	CLINIC	41	0	3,497	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	232	0	33	0		90.01
90.02	09002	SURGICAL CLINIC	71	0	0	0		90.02
90.03	09003	OP CLINIC	3	0	348	0		90.03
91.00	09100	EMERGENCY	196	2,837	6,091	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	174	0	261	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,053	10,358	35,528	11,870	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments					232	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,053	10,358	35,528	11,870	232	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	436,831	0	436,831		30.00
31.00	03100	INTENSIVE CARE UNIT	78,048	0	78,048		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	211,789	0	211,789		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,526	0	156,526		54.00
60.00	06000	LABORATORY	40,177	0	40,177		60.00
65.00	06500	RESPIRATORY THERAPY	36,828	0	36,828		65.00
66.00	06600	PHYSICAL THERAPY	201,260	0	201,260		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,264	0	42,264		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,536	0	9,536		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,955	0	22,955		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	30,322	0	30,322		88.00
90.00	09000	CLINIC	42,503	0	42,503		90.00
90.01	09001	ORTHOPAEDIC CLINIC	207,308	0	207,308		90.01
90.02	09002	SURGICAL CLINIC	1,834	0	1,834		90.02
90.03	09003	OP CLINIC	441	0	441		90.03
91.00	09100	EMERGENCY	114,608	0	114,608		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	105,295	0	105,295		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,738,525	0	1,738,525		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,191	0	7,191		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,917	0	16,917		192.00
200.00		Cross Foot Adjustments	232	0	232		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,762,865	0	1,762,865		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	66,079					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		66,079				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144	144	10,521,939			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,349	4,349	1,148,999	-4,229,323	21,760,874	5.00
7.00	00700	OPERATION OF PLANT	2,580	2,580	171,610	0	1,068,831	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	646	646	228,500	0	465,063	9.00
10.00	01000	DIETARY	4,104	4,104	102,941	0	303,854	10.00
11.00	01100	CAFETERIA	0	0	242,992	0	366,994	11.00
13.00	01300	NURSING ADMINISTRATION	310	310	210,496	0	297,331	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,166	1,166	334,380	0	507,170	16.00
17.00	01700	SOCIAL SERVICE	385	385	135,537	0	193,242	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	36,873	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,095	10,095	1,227,751	0	1,916,615	30.00
31.00	03100	INTENSIVE CARE UNIT	2,530	2,530	265,351	0	409,718	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,978	6,978	611,941	0	1,216,779	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,888	4,888	620,025	0	1,744,972	54.00
60.00	06000	LABORATORY	1,008	1,008	659,677	0	1,370,537	60.00
65.00	06500	RESPIRATORY THERAPY	1,110	1,110	470,625	0	674,516	65.00
66.00	06600	PHYSICAL THERAPY	6,912	6,912	656,791	0	1,096,674	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,326	1,326	52,450	0	967,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,782,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506	506	347,255	0	1,615,187	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,002	1,002	170,930	0	271,553	88.00
90.00	09000	CLINIC	1,335	1,335	164,018	0	291,562	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,200	7,200	561,731	0	1,056,028	90.01
90.02	09002	SURGICAL CLINIC	0	0	151,576	0	319,219	90.02
90.03	09003	OP CLINIC	0	0	11,728	0	16,000	90.03
91.00	09100	EMERGENCY	3,283	3,283	964,723	0	1,792,672	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	3,568	561,715	0	920,443	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,425	65,425	10,073,742	-4,229,323	20,701,614	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256	256	0	0	6,830	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	398	398	448,197	0	1,052,430	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)	603,172	1,159,693	3,016,247		4,229,323	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.128044	17.550099	0.286663		0.194354	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,841		116,442	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000365		0.005351	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (POUNDS)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	59,006					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,740				8.00
9.00	00900	HOUSEKEEPING	646	0	19,740			9.00
10.00	01000	DIETARY	4,104	350	350	9,219		10.00
11.00	01100	CAFETERIA	0	0	0	0	15,590	11.00
13.00	01300	NURSING ADMINISTRATION	310	0	0	0	202	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,166	0	0	0	851	16.00
17.00	01700	SOCIAL SERVICE	385	0	0	0	220	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	269	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,095	8,846	8,846	8,916	2,507	30.00
31.00	03100	INTENSIVE CARE UNIT	2,530	0	0	303	412	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,978	3,646	3,646	0	1,034	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,888	1,302	1,302	0	998	54.00
60.00	06000	LABORATORY	1,008	77	77	0	1,175	60.00
65.00	06500	RESPIRATORY THERAPY	1,110	173	173	0	826	65.00
66.00	06600	PHYSICAL THERAPY	6,912	1,636	1,636	0	987	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,326	0	0	0	111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506	0	0	0	351	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,002	0	0	0	195	88.00
90.00	09000	CLINIC	1,335	40	40	0	315	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,200	0	0	0	1,763	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	540	90.02
90.03	09003	OP CLINIC	0	0	0	0	21	90.03
91.00	09100	EMERGENCY	3,283	3,641	3,641	0	1,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	29	29	0	1,322	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,352	19,740	19,740	9,219	15,590	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	398	0	0	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)	1,276,563	0	569,426	461,793	438,321	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.634461	0.000000	28.846302	50.091442	28.115523	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,611	0	20,623	116,706	2,053	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.264465	0.000000	1.044732	12.659291	0.131687	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/20/2014 2:57 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,444					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	71,455				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,073			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,507	10,765	2,972			30.00
31.00	03100	INTENSIVE CARE UNIT	412	0	101			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,034	8,366	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,875	0	0		54.00
60.00	06000	LABORATORY	0	8,450	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,500	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	350	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,575	0	0		88.00
90.00	09000	CLINIC	0	7,033	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	66	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0		90.02
90.03	09003	OP CLINIC	0	700	0	0		90.03
91.00	09100	EMERGENCY	1,491	12,250	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	525	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,444	71,455	3,073	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	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)	367,504	654,893	245,313	51,602		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	67.506245	9.165111	79.828506	516.020000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,358	35,528	11,870	232		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.902645	0.497208	3.862675	2.320000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/20/2014 2:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,784,955		3,784,955	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	606,721		606,721	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,884,951		1,884,951	0	0	50.00
53.00	05300	ANESTHESIOLOGY	51,602		51,602	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,419,306		2,419,306	0	0	54.00
60.00	06000	LABORATORY	1,771,416		1,771,416	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	889,916	0	889,916	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,537,505	0	1,537,505	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,187,654		1,187,654	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,128,366		2,128,366	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,949,921		1,949,921	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	365,926		365,926	0	0	88.00
90.00	09000	CLINIC	451,578		451,578	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,467,212		1,467,212	0	0	90.01
90.02	09002	SURGICAL CLINIC	396,442		396,442	0	0	90.02
90.03	09003	OP CLINIC	26,116		26,116	0	0	90.03
91.00	09100	EMERGENCY	2,571,985		2,571,985	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	668,696		668,696		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,219,345		1,219,345	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,379,613	0	25,379,613	0	0	200.00
201.00		Less Observation Beds	668,696		668,696		0	201.00
202.00		Total (see instructions)	24,710,917	0	24,710,917	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/20/2014 2:57 pm

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	3,112,900		3,112,900			30.00
31.00	03100	INTENSIVE CARE UNIT	129,669		129,669			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,126,948	5,183,774	9,310,722	0.202449	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	726,643	1,203,721	1,930,364	0.026732	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	711,142	9,953,158	10,664,300	0.226860	0.000000	54.00
60.00	06000	LABORATORY	1,035,964	8,126,821	9,162,785	0.193327	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	374,218	1,567,958	1,942,176	0.458206	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	474,240	2,190,314	2,664,554	0.577022	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,417,909	975,605	2,393,514	0.496197	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,318,066	290,250	3,608,316	0.589850	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,604,501	3,754,434	5,358,935	0.363864	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	410,933	410,933			88.00
90.00	09000	CLINIC	0	375,274	375,274	1.203329	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	63	325,481	325,544	4.506955	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	52,688	52,688	7.524332	0.000000	90.02
90.03	09003	OP CLINIC	0	16,635	16,635	1.569943	0.000000	90.03
91.00	09100	EMERGENCY	65,513	4,625,911	4,691,424	0.548231	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,850	397,795	410,645	1.628404	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,533,669	1,533,669	0.795051	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,110,626	40,984,421	58,095,047			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,110,626	40,984,421	58,095,047			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/20/2014 2:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
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
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
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0.000000	90.02
90.03	09003	OP CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

		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	3,784,955		3,784,955	0	3,784,955	30.00
31.00	03100	INTENSIVE CARE UNIT	606,721		606,721	0	606,721	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,884,951		1,884,951	0	1,884,951	50.00
53.00	05300	ANESTHESIOLOGY	51,602		51,602	0	51,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,419,306		2,419,306	0	2,419,306	54.00
60.00	06000	LABORATORY	1,771,416		1,771,416	0	1,771,416	60.00
65.00	06500	RESPIRATORY THERAPY	889,916	0	889,916	0	889,916	65.00
66.00	06600	PHYSICAL THERAPY	1,537,505	0	1,537,505	0	1,537,505	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,187,654		1,187,654	0	1,187,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,128,366		2,128,366	0	2,128,366	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,949,921		1,949,921	0	1,949,921	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	365,926		365,926	0	365,926	88.00
90.00	09000	CLINIC	451,578		451,578	0	451,578	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,467,212		1,467,212	0	1,467,212	90.01
90.02	09002	SURGICAL CLINIC	396,442		396,442	0	396,442	90.02
90.03	09003	OP CLINIC	26,116		26,116	0	26,116	90.03
91.00	09100	EMERGENCY	2,571,985		2,571,985	0	2,571,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	668,696		668,696		668,696	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,219,345		1,219,345	0	1,219,345	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,379,613	0	25,379,613	0	25,379,613	200.00
201.00		Less Observation Beds	668,696		668,696		668,696	201.00
202.00		Total (see instructions)	24,710,917	0	24,710,917	0	24,710,917	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

		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	3,112,900		3,112,900			30.00
31.00	03100	INTENSIVE CARE UNIT	129,669		129,669			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,126,948	5,183,774	9,310,722	0.202449	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	726,643	1,203,721	1,930,364	0.026732	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	711,142	9,953,158	10,664,300	0.226860	0.000000	54.00
60.00	06000	LABORATORY	1,035,964	8,126,821	9,162,785	0.193327	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	374,218	1,567,958	1,942,176	0.458206	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	474,240	2,190,314	2,664,554	0.577022	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,417,909	975,605	2,393,514	0.496197	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,318,066	290,250	3,608,316	0.589850	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,604,501	3,754,434	5,358,935	0.363864	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	410,933	410,933	0.890476	0.000000	88.00
90.00	09000	CLINIC	0	375,274	375,274	1.203329	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	63	325,481	325,544	4.506955	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	52,688	52,688	7.524332	0.000000	90.02
90.03	09003	OP CLINIC	0	16,635	16,635	1.569943	0.000000	90.03
91.00	09100	EMERGENCY	65,513	4,625,911	4,691,424	0.548231	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,850	397,795	410,645	1.628404	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,533,669	1,533,669	0.795051	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,110,626	40,984,421	58,095,047			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,110,626	40,984,421	58,095,047			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
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
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 5/20/2014 2:57 pm

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	211,789	9,310,722	0.022747	2,580,989	58,710	50.00
53.00	05300	ANESTHESIOLOGY	0	1,930,364	0.000000	441,502	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,526	10,664,300	0.014678	448,237	6,579	54.00
60.00	06000	LABORATORY	40,177	9,162,785	0.004385	761,494	3,339	60.00
65.00	06500	RESPIRATORY THERAPY	36,828	1,942,176	0.018962	321,485	6,096	65.00
66.00	06600	PHYSICAL THERAPY	201,260	2,664,554	0.075532	248,729	18,787	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,264	2,393,514	0.017658	885,581	15,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,536	3,608,316	0.002643	2,110,077	5,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,955	5,358,935	0.004284	1,045,301	4,478	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	30,322	410,933	0.073788	0	0	88.00
90.00	09000	CLINIC	42,503	375,274	0.113259	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	207,308	325,544	0.636805	42	27	90.01
90.02	09002	SURGICAL CLINIC	1,834	52,688	0.034809	0	0	90.02
90.03	09003	OP CLINIC	441	16,635	0.026510	0	0	90.03
91.00	09100	EMERGENCY	114,608	4,691,424	0.024429	2,249	55	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	410,645	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,118,351	53,318,809		8,845,686	119,286	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/20/2014 2:57 pm

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	51,602	0	0	0	51,602	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
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	51,602	0	0	0	51,602	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/20/2014 2:57 pm

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	9,310,722	0.000000	0.000000	2,580,989	50.00
53.00	05300	ANESTHESIOLOGY	0	1,930,364	0.026732	0.000000	441,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,664,300	0.000000	0.000000	448,237	54.00
60.00	06000	LABORATORY	0	9,162,785	0.000000	0.000000	761,494	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,942,176	0.000000	0.000000	321,485	65.00
66.00	06600	PHYSICAL THERAPY	0	2,664,554	0.000000	0.000000	248,729	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,393,514	0.000000	0.000000	885,581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,608,316	0.000000	0.000000	2,110,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,358,935	0.000000	0.000000	1,045,301	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	410,933	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	375,274	0.000000	0.000000	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	325,544	0.000000	0.000000	42	90.01
90.02	09002	SURGICAL CLINIC	0	52,688	0.000000	0.000000	0	90.02
90.03	09003	OP CLINIC	0	16,635	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,691,424	0.000000	0.000000	2,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	410,645	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	53,318,809			8,845,686	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/20/2014 2:57 pm

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	11,802	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
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
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	11,802	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/20/2014 2:57 pm

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	0.202449	0	1,481,399	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026732	0	338,804	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226860	0	4,160,200	0	0	54.00
60.00	06000	LABORATORY	0.193327	0	4,076,259	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.458206	0	630,147	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.577022	0	794,946	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496197	0	301,290	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589850	0	49,335	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.363864	0	1,720,338	1,821	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.203329	0	11,305	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.506955	0	99,583	0	0	90.01
90.02	09002	SURGICAL CLINIC	7.524332	0	23,335	0	0	90.02
90.03	09003	OP CLINIC	1.569943	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.548231	0	1,403,330	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.628404	0	372,493	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.795051		0			95.00
200.00		Subtotal (see instructions)		0	15,462,764	1,821	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	15,462,764	1,821	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/20/2014 2:57 pm

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	299,908	0		50.00
53.00	05300	ANESTHESIOLOGY	9,057	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	943,783	0		54.00
60.00	06000	LABORATORY	788,051	0		60.00
65.00	06500	RESPIRATORY THERAPY	288,737	0		65.00
66.00	06600	PHYSICAL THERAPY	458,701	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,499	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	29,100	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	625,969	663		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	13,604	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	448,816	0		90.01
90.02	09002	SURGICAL CLINIC	175,580	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	769,349	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	606,569	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,606,723	663		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,606,723	663		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V | Date/Time Prepared: 5/20/2014 2:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	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	0.202449	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026732	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226860	0	0	0	0	54.00
60.00	06000	LABORATORY	0.193327	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.458206	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.577022	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496197	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589850	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.363864	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.203329	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.506955	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	7.524332	0	0	0	0	90.02
90.03	09003	OP CLINIC	1.569943	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.548231	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.628404	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.795051		0			95.00
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: 141327 | Component CCN: 14Z327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V | Date/Time Prepared: 5/20/2014 2:57 pm

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
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
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

		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	0.202449	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026732	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226860	0	0	0	0	54.00
60.00	06000	LABORATORY	0.193327	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.458206	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.577022	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496197	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589850	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.363864	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.890476				0	88.00
90.00	09000	CLINIC	1.203329	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.506955	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	7.524332	0	0	0	0	90.02
90.03	09003	OP CLINIC	1.569943	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.548231	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.628404	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.795051	0	0			95.00
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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

		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
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
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/20/2014 2:57 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,603	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,180	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,549	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	386	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	37	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,809	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)	386	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	160.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	160.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,784,955	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)	5,920	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)	414,980	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,369,975	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)	3,369,975	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)	1,059.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,917,070	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)	1,917,070	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/20/2014 2:57 pm

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	606,721	101	6,007.14	50	300,357	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,139,874	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,357,301	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)	409,060	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)	409,060	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)	631	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,059.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	668,696	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/20/2014 2:57 pm

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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,603	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,180	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,549	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	386	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	37	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)	98	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	37	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	90.06	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	90.06	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,784,955	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)	3,332	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)	412,673	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,372,282	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)	3,372,282	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)	1,060.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	103,926	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)	103,926	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

	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	606,721	101	6,007.14	51	306,364	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	410,290	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)	410,290	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)	3,332	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)	3,332	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)	631	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,060.47	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	669,157	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

	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	3,372,282	0.000000	669,157	0	90.00
91.00	Nursing School cost	0	3,372,282	0.000000	669,157	0	91.00
92.00	Allied health cost	0	3,372,282	0.000000	669,157	0	92.00
93.00	All other Medical Education	0	3,372,282	0.000000	669,157	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/20/2014 2:57 pm

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		2,036,702		30.00
31.00	03100	INTENSIVE CARE UNIT		95,559		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202449	2,580,989	522,519	50.00
53.00	05300	ANESTHESIOLOGY	0.026732	441,502	11,802	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226860	448,237	101,687	54.00
60.00	06000	LABORATORY	0.193327	761,494	147,217	60.00
65.00	06500	RESPIRATORY THERAPY	0.458206	321,485	147,306	65.00
66.00	06600	PHYSICAL THERAPY	0.577022	248,729	143,522	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496197	885,581	439,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589850	2,110,077	1,244,629	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.363864	1,045,301	380,347	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.203329	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.506955	42	189	90.01
90.02	09002	SURGICAL CLINIC	7.524332	0	0	90.02
90.03	09003	OP CLINIC	1.569943	0	0	90.03
91.00	09100	EMERGENCY	0.548231	2,249	1,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.628404	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		8,845,686	3,139,874	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)		8,845,686		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/20/2014 2:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202449	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026732	854	23	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226860	19,366	4,393	54.00
60.00	06000	LABORATORY	0.193327	50,627	9,788	60.00
65.00	06500	RESPIRATORY THERAPY	0.458206	43,545	19,953	65.00
66.00	06600	PHYSICAL THERAPY	0.577022	108,768	62,762	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.496197	77,514	38,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.589850	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.363864	181,928	66,197	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.203329	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.506955	21	95	90.01
90.02	09002	SURGICAL CLINIC	7.524332	0	0	90.02
90.03	09003	OP CLINIC	1.569943	0	0	90.03
91.00	09100	EMERGENCY	0.548231	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.628404	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		482,623	201,673	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)		482,623		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/20/2014 2:57 pm

Title XIX | Hospital

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	0	0	90.01
90.02	09002	SURGICAL CLINIC	0.000000	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141327	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/20/2014 2:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,607,386	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)	5,607,386	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)	5,663,460	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)	60,508	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,265,793	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)	3,337,159	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)	3,337,159	30.00
31.00	Primary payer payments	869	31.00
32.00	Subtotal (line 30 minus line 31)	3,336,290	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)	116,269	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	102,317	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,438,607	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)	3,438,607	40.00
40.01	Sequestration adjustment (see instructions)	51,923	40.01
41.00	Interim payments	3,257,262	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	129,422	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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I Date/Time Prepared: 5/20/2014 2:57 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,636,472		3,249,359	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		43,345		259,842	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	07/22/2013	2,745		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	12/20/2013	11,996	07/22/2013	163,554	3.50
3.51			0	12/20/2013	88,385	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)		-9,251		-251,939	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,670,566		3,257,262	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		252,717		129,422	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,923,283		3,386,684	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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/20/2014 2:57 pm

Component CCN: 14Z327 | 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		677,611		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	07/22/2013	32,439		0	3.50
3.51		12/20/2013	27,810		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)		-60,249		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)		617,362		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		16,395		0	6.02
7.00	Total Medicare program liability (see instructions)		600,967		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: 141327	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/20/2014 2:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	653	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,859	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	27	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,650	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	58,095,047	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	310,691	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	12,800	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	11,718	8.00
9.00	Sequestration adjustment amount (see instructions)	234	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	11,484	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)	11,484	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141327 Component CCN: 14Z327	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2 Date/Time Prepared: 5/20/2014 2:57 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	413,151	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)	203,690	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	386	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)	616,841	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	616,841	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)	616,841	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,660	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)	610,181	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)	610,181	0	19.00
19.01	Sequestration adjustment (see instructions)	9,214	0	19.01
20.00	Interim payments	617,362	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	-16,395	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: 141327	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/20/2014 2:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	5,357,301	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	5,357,301	4.00
5.00	Primary payer payments	5,480	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,405,394	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,405,394	19.00
20.00	Deductibles (exclude professional component)	416,740	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	4,988,654	22.00
23.00	Coinsurance	2,368	23.00
24.00	Subtotal (line 22 minus line 23)	4,986,286	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,179	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	12,478	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)	4,998,764	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	4,998,764	30.00
30.01	Sequestration adjustment (see instructions)	75,481	30.01
31.00	Interim payments	4,670,566	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	252,717	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G | Date/Time Prepared: 5/20/2014 2:57 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	969,407	0	0	0	1.00
2.00	Temporary investments	7,358,018	0	0	0	2.00
3.00	Notes receivable	18,529	0	0	0	3.00
4.00	Accounts receivable	14,677,835	0	0	0	4.00
5.00	Other receivable	33,661	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,297,125	0	0	0	6.00
7.00	Inventory	576,599	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	548,425	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)	16,885,349	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	32,680,879	0	0	0	15.00
16.00	Accumulated depreciation	-19,656,446	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)	13,024,433	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	715,845	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	715,845	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,625,627	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,026,847	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,069,247	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,387	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,055,888	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,156,369	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,105,050	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	7,105,050	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	11,261,419	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	19,364,208				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)	19,364,208	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,625,627	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-1 | Date/Time Prepared: 5/20/2014 2:57 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,544,106		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,820,102				2.00
3.00	Total (sum of line 1 and line 2)		19,364,208		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,364,208		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)		19,364,208		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	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: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/20/2014 2:57 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,523,546		3,523,546	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,523,546		3,523,546	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	129,669		129,669	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)	129,669		129,669	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,653,215		3,653,215	17.00
18.00	Ancillary services	14,551,193	39,092,104	53,643,297	18.00
19.00	Outpatient services	0	505,937	505,937	19.00
20.00	RURAL HEALTH CLINIC	0	410,933	410,933	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,533,669	1,533,669	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	34,309	9,764,994	9,799,303	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,238,717	51,307,637	69,546,354	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,860,780		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON-OPERATING EXPENSES	4,268,539			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)		4,268,539		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,592,241		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141327	Period: From 01/01/2013 To 12/31/2013	Worksheet G-3 Date/Time Prepared: 5/20/2014 2:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	69,546,354	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,550,382	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,995,972	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,592,241	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,403,731	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	2,551,322	24.00
24.01	NON-OPERATING DEDUCTIONS	3,104,960	24.01
25.00	Total other income (sum of lines 6-24)	5,656,282	25.00
26.00	Total (line 5 plus line 25)	9,060,013	26.00
27.00	NON-OPERATING G/L	1,204,342	27.00
27.01	NON-OPERATING REVENUE	6,035,569	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	7,239,911	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,820,102	29.00

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

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/20/2014 2:57 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	99,462	0	99,462	0	99,462	2.00
3.00	Nurse Practitioner	23,484	0	23,484	0	23,484	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	47,984	0	47,984	0	47,984	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)	170,930	0	170,930	0	170,930	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	4,692	4,692	-1,038	3,654	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	4,692	4,692	-1,038	3,654	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	170,930	4,692	175,622	-1,038	174,584	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	21,239	21,239	0	21,239	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	21,239	21,239	0	21,239	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	170,930	25,931	196,861	-1,038	195,823	32.00

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

Provider CCN: 141327 | Component CCN: 148501 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/20/2014 2:57 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	99,462		2.00
3.00	Nurse Practitioner	0	23,484		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	47,984		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	170,930		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	3,654		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	3,654		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	174,584		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	21,239		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	21,239		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	195,823		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141327 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2

Component CCN: 148501 | Date/Time Prepared: 5/20/2014 2:57 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	14	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.19	4,640	2,100	2,499		3.00
4.00	Subtotal (sum of lines 1-3)	1.19	4,654		2,499	4,654	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.19	4,654			4,654	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)					174,584	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					174,584	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					21,239	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					170,103	15.00
16.00	Total overhead (sum of lines 14 and 15)					191,342	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					191,342	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					191,342	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					365,926	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141327 Component CCN: 148501	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3 Date/Time Prepared: 5/20/2014 2:57 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		365,926	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		365,926	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,654	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,654	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		78.63	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	78.63	78.63	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	276	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	21,702	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) *		21,702	16.00
16.01	Total program charges (see instructions)(from contractor's records)		27,283	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.)		13,621	16.04
16.05	Total program cost (see instructions)		13,621	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,676	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,521	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		13,621	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		13,621	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		13,621	26.00
26.01	Sequestration adjustment (see instructions)		206	26.01
27.00	Interim payments		11,432	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		1,983	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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141327 Component CCN: 148501	Period: From 01/01/2013 To 12/31/2013	Worksheet M-5 Date/Time Prepared: 5/20/2014 2:57 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		11,432	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)		11,432	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		1,983	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		13,415	7.00

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