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: 141346	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/21/2014 2:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/21/2014 Time: 2:22 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 FAYETTE COUNTY HOSPITAL (141346) 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	143,370	-530,149	129,126	1,878,210	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	-29,756	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	7,906	0		0	7.00
10.00	RURAL HEALTH CLINIC (RHC) VANDALIA I	0		39,641		0	10.00
10.01	RURAL HEALTH CLINIC (RHC) ST ELMO II	0		11,646		0	10.01
200.00	Total	0	121,520	-478,862	129,126	1,878,210	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2014 2:21 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SEVENTH & TAYLOR	PO Box:			1.00
2.00	City: VANDALIA	State: IL	Zip Code: 62471-	County: FAYETTE	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	FAYETTE COUNTY HOSPITAL	141346	14999	1	04/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FAYETTE COUNTY SNF	14Z346	14999		04/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAYETTE COUNTY SNF	145499	14999		07/01/1983	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CONFIDENCE MEDICAL - VANDALIA	148527	14999		06/01/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CONFIDENCE MEDICAL - ST ELMO	148528	14999		06/01/2013	N	O	N	15.01
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2014 2:21 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2014 2:21 pm

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2014 2:21 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

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		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

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		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	132,184	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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2014 2:21 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	03/31/2013	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	04/18/2014	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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 5/21/2014 2:21 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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 5/21/2014 2:21 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)	04/18/2014			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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 5/21/2014 2:21 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	44,160.00	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	44,160.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	4,728.00	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	48,888.00	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	44.00	85	31,025		0	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 (RHC) VANDALIA	88.00				0	26.00
26.01	RURAL HEALTH CLINIC (RHC) ST ELMO	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		110				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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2014 2:21 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)	1,461	147	1,840			1.00
2.00	HMO and other (see instructions)	4	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	1,289	0	1,289			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		94	94			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,750	241	3,223			7.00
8.00	INTENSIVE CARE UNIT	143	0	197			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)	2,893	241	3,420	0.00	156.53	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	897	9,685	20,849	0.00	34.85	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 (RHC) VANDALIA	585	0	1,813	0.00	3.09	26.00
26.01	RURAL HEALTH CLINIC (RHC) ST ELMO	232	0	1,068	0.00	1.19	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	195.66	27.00
28.00	Observation Bed Days		0	584			28.00
29.00	Ambulance Trips	472					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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 5/21/2014 2:21 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	468	55	628	1.00
2.00	HMO and other (see instructions)			1			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	468	55	628	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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 (RHC) VANDALIA	0.00					26.00
26.01	RURAL HEALTH CLINIC (RHC) ST ELMO	0.00					26.01
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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-3 Part IV Date/Time Prepared: 5/21/2014 2:21 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	71,906	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,786,885	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	40,453	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	4,091	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)	34,077	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	223,381	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	625,667	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	114,683	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	23,341	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,924,484	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-7 | Date/Time Prepared: 5/21/2014 2:21 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/01/2005	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	2	0	2	7.00
8.00		RHL	14	0	14	8.00
9.00		RMX	7	0	7	9.00
10.00		RML	28	0	28	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	79	0	79	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	14	0	14	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	52	0	52	17.00
18.00		RHC	37	0	37	18.00
19.00		RHB	85	0	85	19.00
20.00		RHA	137	0	137	20.00
21.00		RMC	37	0	37	21.00
22.00		RMB	30	0	30	22.00
23.00		RMA	114	0	114	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	47	0	47	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	97	0	97	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	6	0	6	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	3	0	3	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	24	0	24	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	38	0	38	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	25	0	25	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	14	0	14	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-7 | Date/Time Prepared: 5/21/2014 2:21 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	7	0	7	199.00
200.00	TOTAL		897	0	897	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	14999	14999	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	186,362			207.00

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

Provider CCN: 141346 Component CCN: 148527 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 | Date/Time Prepared: 5/21/2014 2:21 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1442 N 8TH STREET, SUITE C	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	VANDALIA	IL	62471	2.00

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

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

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

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

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

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

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

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

Provider CCN: 141346
Component CCN: 148527

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

Worksheet S-8
Date/Time Prepared:
5/21/2014 2:21 pm

Rural Health Clinic (RHC) I

Cost

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

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

Provider CCN: 141346 Component CCN: 148528 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-8 Date/Time Prepared: 5/21/2014 2:21 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	428 N MAIN STREET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	SAINT ELMO	IL	62458	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			13:00	17:00	08:00	11.00

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	12:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141346 Component CCN: 148528	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 5/21/2014 2:21 pm
		Rural Health Clinic (RHC) II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet S-10 | Date/Time Prepared: 5/21/2014 2:21 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)	0.343220	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,831,061	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	2,191,377	5.00
6.00	Medicaid charges	12,353,008	6.00
7.00	Medicaid cost (line 1 times line 6)	4,239,799	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)	0	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)	0	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	539,019	0	539,019	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	185,002	0	185,002	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	185,002	0	185,002	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,582,812	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	820,034	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,762,778	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	605,021	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	790,023	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	790,023	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/21/2014 2:21 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		1,480,607	1,480,607	-407,481	1,073,126	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	452,621	452,621	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	73,099	2,394,077	2,467,176	8,802	2,475,978	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	561,354	2,499,257	3,060,611	22,545	3,083,156	5.00
7.00	00700	OPERATION OF PLANT	238,563	67,747	306,310	20,805	327,115	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	521,685	521,685	0	521,685	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	10,105	10,105	0	10,105	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	75,992	65,338	141,330	0	141,330	8.00
9.00	00900	HOUSEKEEPING	372,744	90,210	462,954	0	462,954	9.00
10.00	01000	DIETARY	313,495	402,362	715,857	-118,521	597,336	10.00
11.00	01100	CAFETERIA	0	0	0	118,521	118,521	11.00
13.00	01300	NURSING ADMINISTRATION	281,332	24,532	305,864	0	305,864	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,028	78,322	132,350	0	132,350	14.00
15.00	01500	PHARMACY	189,751	153,013	342,764	0	342,764	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	251,688	119,950	371,638	0	371,638	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	283,000	283,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	968,960	321,069	1,290,029	-56,400	1,233,629	30.00
31.00	03100	INTENSIVE CARE UNIT	207,665	21,706	229,371	-4,054	225,317	31.00
44.00	04400	SKILLED NURSING FACILITY	1,381,143	463,779	1,844,922	-61,206	1,783,716	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	489,667	644,184	1,133,851	-483,631	650,220	50.00
53.00	05300	ANESTHESIOLOGY	0	293,632	293,632	-290,189	3,443	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,153	814,939	1,243,092	-57,606	1,185,486	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	175,186	175,186	-3,349	171,837	55.00
60.00	06000	LABORATORY	495,804	775,430	1,271,234	-27,964	1,243,270	60.00
65.00	06500	RESPIRATORY THERAPY	195,807	120,358	316,165	-30,095	286,070	65.00
66.00	06600	PHYSICAL THERAPY	310,295	46,998	357,293	-2,622	354,671	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,189	5,668	72,857	-763	72,094	67.00
68.00	06800	SPEECH PATHOLOGY	28,126	3,611	31,737	0	31,737	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	56,798	56,798	602,052	658,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	158,591	158,591	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	719,542	719,542	40,750	760,292	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	254,977	63,841	318,818	0	318,818	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	77,327	20,558	97,885	0	97,885	88.01
90.00	09000	CLINIC	0	597,068	597,068	-1,384	595,684	90.00
90.01	09002	WOUND CARE	0	24,700	24,700	0	24,700	90.01
91.00	09100	EMERGENCY	466,178	1,272,781	1,738,959	291,246	2,030,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	391,566	100,062	491,628	-335,278	156,350	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,174,903	14,449,115	22,624,018	118,390	22,742,408	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,248,237	876,439	2,124,676	-29,900	2,094,776	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	88,490	88,490	-88,490	0	192.01
192.02	19202	PUBLIC RELATIONS	0	27,146	27,146	0	27,146	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		TOTAL (SUM OF LINES 118-199)	9,423,140	15,441,190	24,864,330	0	24,864,330	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A | Date/Time Prepared: 5/21/2014 2:21 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	-182,657	890,469		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	452,621		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-175	2,475,803		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,279	3,068,877		5.00
7.00	00700	OPERATION OF PLANT	-1,840	325,275		7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	521,685		7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	10,105		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	141,330		8.00
9.00	00900	HOUSEKEEPING	0	462,954		9.00
10.00	01000	DIETARY	-60,660	536,676		10.00
11.00	01100	CAFETERIA	0	118,521		11.00
13.00	01300	NURSING ADMINISTRATION	0	305,864		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	132,350		14.00
15.00	01500	PHARMACY	0	342,764		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,958	363,680		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-283,000	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-215,214	1,018,415		30.00
31.00	03100	INTENSIVE CARE UNIT	0	225,317		31.00
44.00	04400	SKILLED NURSING FACILITY	-185,292	1,598,424		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	650,220		50.00
53.00	05300	ANESTHESIOLOGY	0	3,443		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	677	1,186,163		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	171,837		55.00
60.00	06000	LABORATORY	0	1,243,270		60.00
65.00	06500	RESPIRATORY THERAPY	0	286,070		65.00
66.00	06600	PHYSICAL THERAPY	0	354,671		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	72,094		67.00
68.00	06800	SPEECH PATHOLOGY	0	31,737		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	658,850		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	158,591		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	760,292		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	318,818		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	97,885		88.01
90.00	09000	CLINIC	0	595,684		90.00
90.01	09002	WOUND CARE	0	24,700		90.01
91.00	09100	EMERGENCY	-819,458	1,210,747		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	156,350		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,769,856	20,972,552		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,094,776		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		192.01
192.02	19202	PUBLIC RELATIONS	0	27,146		192.02
192.03	19203	PERSONAL LAUNDRY	0	0		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0		192.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,769,856	23,094,474		200.00

RECLASSIFICATIONS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/21/2014 2:21 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	51,904	66,617		1.00
	TOTALS		51,904	66,617		
	B - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	283,000		1.00
	TOTALS		0	283,000		
	D - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	452,621		1.00
	TOTALS		0	452,621		
	E - ER					
1.00	EMERGENCY	91.00	332,037	0		1.00
	TOTALS		332,037	0		
	F - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,842		1.00
	TOTALS		0	2,842		
	G - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,178		1.00
	TOTALS		0	17,178		
	H - EMPLOYEE OCC HEALTH PROCEDURES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6,263	2,539		1.00
	TOTALS		6,263	2,539		
	I - WELLNESS DEPR AND UTILITIES					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	65,160		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,525		2.00
3.00	OPERATION OF PLANT	7.00	0	20,805		3.00
	TOTALS		0	88,490		
	J - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	602,052		1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	158,591		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
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
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	760,643		
	K - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	40,750		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
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	40,750		
500.00	Grand Total: Increases		390,204	1,714,680		500.00

RECLASSIFICATIONS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-6 | Date/Time Prepared: 5/21/2014 2:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	51,904	66,617	0		1.00
	TOTALS		51,904	66,617			
	B - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	283,000	0		1.00
	TOTALS		0	283,000			
	D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	452,621	9		1.00
	TOTALS		0	452,621			
	E - ER						
1.00	AMBULANCE SERVICES	95.00	332,037	0	0		1.00
	TOTALS		332,037	0			
	F - INTEREST						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,842	9		1.00
	TOTALS		0	2,842			
	G - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	17,178	9		1.00
	TOTALS		0	17,178			
	H - EMPLOYEE OCC HEALTH PROCEDURES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	6,263	2,539	0		1.00
	TOTALS		6,263	2,539			
	I - WELLNESS DEPR AND UTILITIES						
1.00	FAYETTE COUNTY ANNEX	192.01	0	88,490	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	88,490			
	J - MED SUPPLY						
1.00	ADULTS & PEDIATRICS	30.00	0	53,461	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	3,402	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	51,880	0		3.00
4.00	OPERATING ROOM	50.00	0	471,579	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	7,105	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	56,641	0		6.00
8.00	LABORATORY	60.00	0	27,839	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	30,070	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	2,622	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	763	0		11.00
13.00	CLINIC	90.00	0	1,279	0		13.00
14.00	EMERGENCY	91.00	0	39,393	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	454	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14,155	0		16.00
	TOTALS		0	760,643			
	K - PHARMACY						
1.00	ADULTS & PEDIATRICS	30.00	0	2,939	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	652	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	9,326	0		3.00
4.00	OPERATING ROOM	50.00	0	12,052	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	84	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	965	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,349	0		7.00
8.00	LABORATORY	60.00	0	125	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	25	0		9.00
11.00	CLINIC	90.00	0	105	0		11.00
12.00	EMERGENCY	91.00	0	1,398	0		12.00
13.00	AMBULANCE SERVICES	95.00	0	2,787	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,943	0		14.00
	TOTALS		0	40,750			
500.00	Grand Total: Decreases		390,204	1,714,680			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 5/21/2014 2:21 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	26,542,867	816,676	0	816,676	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,542,867	816,676	0	816,676	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,542,867	816,676	0	816,676	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	27,359,543	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,359,543	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	27,359,543	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 5/21/2014 2:21 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	1,480,607	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,480,607	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,480,607				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,480,607				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 5/21/2014 2:21 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	27,359,543	0	27,359,543	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)	27,359,543	0	27,359,543	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	890,469	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	452,621	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,343,090	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	890,469	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	452,621	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,343,090	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/21/2014 2:21 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)	B	-2,842	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,035	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,034,672			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	1,581			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-60,660	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,958	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,840	OPERATION OF PLANT	7.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-283,000	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-179,815	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8 | Date/Time Prepared: 5/21/2014 2:21 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			0		0.00	0	33.00
33.01			0		0.00	0	33.01
33.02			0		0.00	0	33.02
33.03	AHA/IHA	A	-13,244	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	EMPLOYEE BENEFIT OTHER REVENUE	A	-175	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.07			0		0.00	0	33.07
34.00			0		0.00	0	34.00
35.00	RADIOLOGY OTHER	A	-904	RADIOLOGY-DIAGNOSTIC	54.00	0	35.00
36.00	LTC ASSESSMENT	A	-185,292	SKILLED NURSING FACILITY	44.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,769,856				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 5/21/2014 2:21 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	5.00	ADMINISTRATIVE & GENERAL	ALLIANT MANAGEMENT	678,801	678,801	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	BLUE GRASS LEASING	84,454	84,454	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ALLIANT PURCHASING	7,020	7,020	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	BLUE	49,256	49,256	4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	174,408	172,827	4.01
5.00	0		0	993,939	992,358	5.00

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

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

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

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

6.00	B	ALLIANT MGT	100.00		0.00	6.00
7.00	B	BLUEGRASS LEAS	100.00		0.00	7.00
8.00	B	ALLIANT PURCH	100.00		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:	OTHER				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: 141346	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-1 Date/Time Prepared: 5/21/2014 2:21 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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	1,581	0		4.01
5.00	1,581			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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 5/21/2014 2:21 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	91.00	EMERGENCY	1,150,361	819,458	330,902	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	215,214	215,214	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,365,575	1,034,672	330,902		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	91.00	EMERGENCY	0	0	0	819,458		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	215,214		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,034,672		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/21/2014 2:21 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	890,469	890,469				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	452,621		452,621			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,475,803	7,971	491	2,484,265		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,068,877	82,761	228,956	149,249	3,529,843	5.00
7.00	00700	OPERATION OF PLANT	325,275	110,782	10,861	63,428	510,346	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	521,685	0	0	0	521,685	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	10,105	0	0	0	10,105	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	141,330	20,422	403	20,204	182,359	8.00
9.00	00900	HOUSEKEEPING	462,954	3,702	0	99,103	565,759	9.00
10.00	01000	DIETARY	536,676	11,035	3,781	69,550	621,042	10.00
11.00	01100	CAFETERIA	118,521	18,669	0	13,800	150,990	11.00
13.00	01300	NURSING ADMINISTRATION	305,864	4,632	0	74,799	385,295	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,350	5,269	0	14,365	151,984	14.00
15.00	01500	PHARMACY	342,764	8,768	10,445	50,450	412,427	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	363,680	31,298	2,270	66,917	464,165	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,018,415	77,164	6,562	257,621	1,359,762	30.00
31.00	03100	INTENSIVE CARE UNIT	225,317	9,069	0	55,213	289,599	31.00
44.00	04400	SKILLED NURSING FACILITY	1,598,424	166,166	3,742	367,207	2,135,539	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	650,220	50,462	16,865	130,190	847,737	50.00
53.00	05300	ANESTHESIOLOGY	3,443	0	0	0	3,443	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,186,163	39,817	85,958	113,835	1,425,773	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	171,837	0	0	0	171,837	55.00
60.00	06000	LABORATORY	1,243,270	15,791	17,018	131,821	1,407,900	60.00
65.00	06500	RESPIRATORY THERAPY	286,070	26,321	27,434	52,060	391,885	65.00
66.00	06600	PHYSICAL THERAPY	354,671	34,282	3,633	82,499	475,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,094	2,409	2,071	17,864	94,438	67.00
68.00	06800	SPEECH PATHOLOGY	31,737	1,665	0	7,478	40,880	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	658,850	0	0	0	658,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	158,591	0	0	0	158,591	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760,292	0	0	0	760,292	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	318,818	0	0	67,792	386,610	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	97,885	0	0	20,559	118,444	88.01
90.00	09000	CLINIC	595,684	47,141	0	0	642,825	90.00
90.01	09002	WOUND CARE	24,700	0	0	0	24,700	90.01
91.00	09100	EMERGENCY	1,210,747	32,502	277	212,225	1,455,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	156,350	9,361	5,778	15,827	187,316	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,972,552	817,459	426,545	2,154,056	20,543,257	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,313	0	0	4,313	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,094,776	59,159	21,754	330,209	2,505,898	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	9,538	4,322	0	13,860	192.01
192.02	19202	PUBLIC RELATIONS	27,146	0	0	0	27,146	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,094,474	890,469	452,621	2,484,265	23,094,474	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,529,843					5.00
7.00	00700	OPERATION OF PLANT	92,077	602,423				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	94,122	0	615,807			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	1,823	0	0	11,928		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	32,901	18,103	19,595	0	252,958	8.00
9.00	00900	HOUSEKEEPING	102,074	3,282	3,552	0	17,704	9.00
10.00	01000	DIETARY	112,048	9,782	10,588	0	1,736	10.00
11.00	01100	CAFETERIA	27,242	16,549	17,912	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	69,515	4,106	4,444	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,421	4,671	5,056	0	0	14.00
15.00	01500	PHARMACY	74,410	7,772	8,412	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,745	27,744	30,029	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	245,328	68,401	74,037	0	57,605	30.00
31.00	03100	INTENSIVE CARE UNIT	52,249	8,039	8,701	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	385,294	147,299	159,434	0	124,194	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	152,949	44,732	48,418	0	9,938	50.00
53.00	05300	ANESTHESIOLOGY	621	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	257,238	35,296	38,204	0	4,672	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,003	0	0	0	0	55.00
60.00	06000	LABORATORY	254,013	13,997	15,151	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	70,704	23,332	25,254	0	567	65.00
66.00	06600	PHYSICAL THERAPY	85,715	30,389	32,893	0	7,358	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,039	2,135	2,311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,376	1,476	1,597	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,870	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	28,613	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	137,172	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	69,752	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	21,370	0	0	0	0	88.01
90.00	09000	CLINIC	115,978	41,788	0	11,928	0	90.00
90.01	09002	WOUND CARE	4,456	0	0	0	0	90.01
91.00	09100	EMERGENCY	262,647	28,811	31,185	0	15,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	33,796	0	8,982	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,069,561	537,704	545,755	11,928	239,441	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	778	3,823	4,138	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	452,105	52,441	56,762	0	47	192.00
192.01	19201	FAYETTE COUNTY ANNEX	2,501	8,455	9,152	0	105	192.01
192.02	19202	PUBLIC RELATIONS	4,898	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	13,365	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,529,843	602,423	615,807	11,928	252,958	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	692,371					9.00
10.00	01000	DIETARY	11,492	766,688				10.00
11.00	01100	CAFETERIA	19,442	0	232,135			11.00
13.00	01300	NURSING ADMINISTRATION	4,824	0	11,964	480,148		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,488	0	3,675	0	198,295	14.00
15.00	01500	PHARMACY	9,131	0	4,290	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,594	0	10,152	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,360	104,285	29,551	169,010	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,444	4,747	6,273	35,874	0	31.00
44.00	04400	SKILLED NURSING FACILITY	173,049	618,726	61,562	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,553	0	11,024	63,049	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,467	0	13,776	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	16,445	0	18,544	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	27,411	0	6,734	0	0	65.00
66.00	06600	PHYSICAL THERAPY	35,702	0	9,127	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,509	0	1,231	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,734	0	615	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	164,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	33,297	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 (RHC) VANDALIA	0	0	0	30,205	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	11,632	0	88.01
90.00	09000	CLINIC	49,094	38,930	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	33,848	0	27,124	155,129	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,749	0	2,666	15,249	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	616,336	766,688	218,308	480,148	198,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,492	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,610	0	13,827	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	9,933	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	692,371	766,688	232,135	480,148	198,295	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		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
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	516,442					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	648,429				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	41,375	0	2,229,714	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,814	0	417,740	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	36,903	0	3,842,000	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	22,766	0	1,253,166	0	50.00
53.00	05300	ANESTHESIOLOGY	0	33	0	4,097	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	122,606	0	1,939,032	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,740	0	210,580	0	55.00
60.00	06000	LABORATORY	0	125,110	0	1,851,160	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,214	0	569,101	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,690	0	692,959	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,427	0	122,090	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	392	0	54,070	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,932	0	971,650	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,795	0	222,296	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	516,442	70,735	0	1,484,641	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	1,278	0	487,845	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	753	0	152,199	0	88.01
90.00	09000	CLINIC	0	23,591	0	924,134	0	90.00
90.01	09002	WOUND CARE	0	989	0	30,145	0	90.01
91.00	09100	EMERGENCY	0	73,775	0	2,083,937	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,049	0	272,807	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	516,442	618,967	0	19,815,363	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	17,544	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,462	0	3,172,152	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	44,006	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	32,044	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	13,365	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	516,442	648,429	0	23,094,474	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part I | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	Total		
			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
7.01	00701	OPERATION OF PLANT HOSP ONLY			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,229,714		30.00
31.00	03100	INTENSIVE CARE UNIT	417,740		31.00
44.00	04400	SKILLED NURSING FACILITY	3,842,000		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,253,166		50.00
53.00	05300	ANESTHESIOLOGY	4,097		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,939,032		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	210,580		55.00
60.00	06000	LABORATORY	1,851,160		60.00
65.00	06500	RESPIRATORY THERAPY	569,101		65.00
66.00	06600	PHYSICAL THERAPY	692,959		66.00
67.00	06700	OCCUPATIONAL THERAPY	122,090		67.00
68.00	06800	SPEECH PATHOLOGY	54,070		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,650		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	222,296		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,484,641		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	487,845		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	152,199		88.01
90.00	09000	CLINIC	924,134		90.00
90.01	09002	WOUND CARE	30,145		90.01
91.00	09100	EMERGENCY	2,083,937		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	272,807		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,815,363		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,544		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,172,152		192.00
192.01	19201	FAYETTE COUNTY ANNEX	44,006		192.01
192.02	19202	PUBLIC RELATIONS	32,044		192.02
192.03	19203	PERSONAL LAUNDRY	13,365		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0		192.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	23,094,474		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/21/2014 2:21 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	7,971	491	8,462	8,462	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	82,761	228,956	311,717	509	5.00
7.00	00700	OPERATION OF PLANT	0	110,782	10,861	121,643	216	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,422	403	20,825	69	8.00
9.00	00900	HOUSEKEEPING	0	3,702	0	3,702	338	9.00
10.00	01000	DIETARY	0	11,035	3,781	14,816	237	10.00
11.00	01100	CAFETERIA	0	18,669	0	18,669	47	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,632	0	4,632	255	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,269	0	5,269	49	14.00
15.00	01500	PHARMACY	0	8,768	10,445	19,213	172	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,298	2,270	33,568	228	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	77,164	6,562	83,726	878	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,069	0	9,069	188	31.00
44.00	04400	SKILLED NURSING FACILITY	0	166,166	3,742	169,908	1,248	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	50,462	16,865	67,327	444	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,817	85,958	125,775	388	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	15,791	17,018	32,809	449	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,321	27,434	53,755	177	65.00
66.00	06600	PHYSICAL THERAPY	0	34,282	3,633	37,915	281	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,409	2,071	4,480	61	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,665	0	1,665	25	68.00
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 (RHC) VANDALIA	0	0	0	0	231	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	70	88.01
90.00	09000	CLINIC	0	47,141	0	47,141	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	32,502	277	32,779	723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	9,361	5,778	15,139	54	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	817,459	426,545	1,244,004	7,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,313	0	4,313	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59,159	21,754	80,913	1,125	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	9,538	4,322	13,860	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	890,469	452,621	1,343,090	8,462	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	312,226					5.00
7.00	00700	OPERATION OF PLANT	8,145	130,004				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	8,326	0	8,326			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	161	0	0	161		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,910	3,907	265	0	27,976	8.00
9.00	00900	HOUSEKEEPING	9,029	708	48	0	1,958	9.00
10.00	01000	DIETARY	9,911	2,111	143	0	192	10.00
11.00	01100	CAFETERIA	2,410	3,571	242	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,149	886	60	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,426	1,008	68	0	0	14.00
15.00	01500	PHARMACY	6,582	1,677	114	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,408	5,987	406	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,700	14,761	1,001	0	6,371	30.00
31.00	03100	INTENSIVE CARE UNIT	4,622	1,735	118	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	34,081	31,786	2,155	0	13,734	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,529	9,653	655	0	1,099	50.00
53.00	05300	ANESTHESIOLOGY	55	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,754	7,617	517	0	517	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,742	0	0	0	0	55.00
60.00	06000	LABORATORY	22,469	3,021	205	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,254	5,035	341	0	63	65.00
66.00	06600	PHYSICAL THERAPY	7,582	6,558	445	0	814	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,507	461	31	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	652	319	22	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,515	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,531	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,134	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	6,170	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	1,890	0	0	0	0	88.01
90.00	09000	CLINIC	10,259	9,018	0	161	0	90.00
90.01	09002	WOUND CARE	394	0	0	0	0	90.01
91.00	09100	EMERGENCY	23,232	6,218	422	0	1,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,989	0	121	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	271,518	116,037	7,379	161	26,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	69	825	56	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,985	11,317	767	0	5	192.00
192.01	19201	FAYETTE COUNTY ANNEX	221	1,825	124	0	12	192.01
192.02	19202	PUBLIC RELATIONS	433	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	1,478	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	312,226	130,004	8,326	161	27,976	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	15,783					9.00
10.00	01000	DIETARY	262	27,672				10.00
11.00	01100	CAFETERIA	443	0	25,382			11.00
13.00	01300	NURSING ADMINISTRATION	110	0	1,308	13,400		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	125	0	402	0	9,347	14.00
15.00	01500	PHARMACY	208	0	469	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	743	0	1,110	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,832	3,764	3,231	4,716	0	30.00
31.00	03100	INTENSIVE CARE UNIT	215	171	686	1,001	0	31.00
44.00	04400	SKILLED NURSING FACILITY	3,946	22,332	6,731	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,198	0	1,205	1,760	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	945	0	1,506	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	375	0	2,028	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	625	0	736	0	0	65.00
66.00	06600	PHYSICAL THERAPY	814	0	998	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57	0	135	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	40	0	67	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,570	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 (RHC) VANDALIA	0	0	0	843	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	325	0	88.01
90.00	09000	CLINIC	1,119	1,405	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	772	0	2,966	4,329	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	222	0	292	426	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,051	27,672	23,870	13,400	9,347	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,404	0	1,512	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	226	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,783	27,672	25,382	13,400	9,347	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		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
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	28,435					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,450				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,156		145,136	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	215		18,020	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	2,815		288,736	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,736		98,606	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3		58	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,351		169,370	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	590		3,332	0	55.00
60.00	06000	LABORATORY	0	9,536		70,892	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,771		68,757	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,273		56,680	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	185		6,917	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	30		2,820	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,207		20,499	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	137		4,238	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,435	5,395		45,964	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	97		7,341	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	57		2,342	0	88.01
90.00	09000	CLINIC	0	1,799		70,902	0	90.00
90.01	09002	WOUND CARE	0	75		469	0	90.01
91.00	09100	EMERGENCY	0	5,627		78,801	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,148		20,391	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,435	47,203	0	1,180,271	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		5,365	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,247		139,275	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		16,268	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0		433	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0		1,478	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0		0	0	192.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,435	49,450	0	1,343,090	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B Part II | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	Total		
			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
7.01	00701	OPERATION OF PLANT HOSP ONLY			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	145,136		30.00
31.00	03100	INTENSIVE CARE UNIT	18,020		31.00
44.00	04400	SKILLED NURSING FACILITY	288,736		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	98,606		50.00
53.00	05300	ANESTHESIOLOGY	58		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,370		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,332		55.00
60.00	06000	LABORATORY	70,892		60.00
65.00	06500	RESPIRATORY THERAPY	68,757		65.00
66.00	06600	PHYSICAL THERAPY	56,680		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,917		67.00
68.00	06800	SPEECH PATHOLOGY	2,820		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,499		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,238		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,964		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	7,341		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	2,342		88.01
90.00	09000	CLINIC	70,902		90.00
90.01	09002	WOUND CARE	469		90.01
91.00	09100	EMERGENCY	78,801		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	20,391		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,180,271		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,365		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	139,275		192.00
192.01	19201	FAYETTE COUNTY ANNEX	16,268		192.01
192.02	19202	PUBLIC RELATIONS	433		192.02
192.03	19203	PERSONAL LAUNDRY	1,478		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0		192.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,343,090		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	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	100,548					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		467,799				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	900	507	9,343,778			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,345	236,635	561,354	-3,529,843	19,564,631	5.00
7.00	00700	OPERATION OF PLANT	12,509	11,225	238,563	0	510,346	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	521,685	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	10,105	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	416	75,992	0	182,359	8.00
9.00	00900	HOUSEKEEPING	418	0	372,744	0	565,759	9.00
10.00	01000	DIETARY	1,246	3,908	261,591	0	621,042	10.00
11.00	01100	CAFETERIA	2,108	0	51,904	0	150,990	11.00
13.00	01300	NURSING ADMINISTRATION	523	0	281,332	0	385,295	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	0	54,028	0	151,984	14.00
15.00	01500	PHARMACY	990	10,795	189,751	0	412,427	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,534	2,346	251,688	0	464,165	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,713	6,782	968,960	0	1,359,762	30.00
31.00	03100	INTENSIVE CARE UNIT	1,024	0	207,665	0	289,599	31.00
44.00	04400	SKILLED NURSING FACILITY	18,763	3,867	1,381,143	0	2,135,539	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,698	17,431	489,667	0	847,737	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,443	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,496	88,841	428,153	0	1,425,773	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	171,837	55.00
60.00	06000	LABORATORY	1,783	17,589	495,804	0	1,407,900	60.00
65.00	06500	RESPIRATORY THERAPY	2,972	28,354	195,807	0	391,885	65.00
66.00	06600	PHYSICAL THERAPY	3,871	3,755	310,295	0	475,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	272	2,140	67,189	0	94,438	67.00
68.00	06800	SPEECH PATHOLOGY	188	0	28,126	0	40,880	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	658,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	158,591	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	760,292	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	254,977	0	386,610	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	77,327	0	118,444	88.01
90.00	09000	CLINIC	5,323	0	0	0	642,825	90.00
90.01	09002	WOUND CARE	0	0	0	0	24,700	90.01
91.00	09100	EMERGENCY	3,670	286	798,215	0	1,455,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,057	5,972	59,529	0	187,316	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,304	440,849	8,101,804	-3,529,843	17,013,414	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	487	0	0	0	4,313	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,680	22,483	1,241,974	0	2,505,898	192.00
192.01	19201	FAYETTE COUNTY ANNEX	1,077	4,467	0	0	13,860	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	27,146	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	890,469	452,621	2,484,265		3,529,843	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.856158	0.967554	0.265874		0.180420	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,462		312,226	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000906		0.015959	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	OPERATION OF PLANT (SQ FT)	OPERATION OF PLANT HOSP ONLY (SQ FT)	OPERATION OF PLANT ANNEX ONLY (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			7.00	7.01	7.02	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	76,737					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	72,471				7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	5,323			7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,306	0	432,540		8.00
9.00	00900	HOUSEKEEPING	418	418	0	30,272	75,070	9.00
10.00	01000	DIETARY	1,246	1,246	0	2,968	1,246	10.00
11.00	01100	CAFETERIA	2,108	2,108	0	0	2,108	11.00
13.00	01300	NURSING ADMINISTRATION	523	523	0	0	523	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	595	0	0	595	14.00
15.00	01500	PHARMACY	990	990	0	0	990	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,534	3,534	0	0	3,534	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,713	8,713	0	98,500	8,713	30.00
31.00	03100	INTENSIVE CARE UNIT	1,024	1,024	0	0	1,024	31.00
44.00	04400	SKILLED NURSING FACILITY	18,763	18,763	0	212,365	18,763	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,698	5,698	0	16,993	5,698	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,496	4,496	0	7,988	4,496	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,783	1,783	0	0	1,783	60.00
65.00	06500	RESPIRATORY THERAPY	2,972	2,972	0	969	2,972	65.00
66.00	06600	PHYSICAL THERAPY	3,871	3,871	0	12,581	3,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	272	272	0	0	272	67.00
68.00	06800	SPEECH PATHOLOGY	188	188	0	0	188	68.00
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 (RHC) VANDALIA	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	0	88.01
90.00	09000	CLINIC	5,323	0	5,323	0	5,323	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,670	3,670	0	26,790	3,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,057	0	0	1,057	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,493	64,227	5,323	409,426	66,826	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	487	487	0	0	487	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,680	6,680	0	80	6,680	192.00
192.01	19201	FAYETTE COUNTY ANNEX	1,077	1,077	0	180	1,077	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	22,854	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	602,423	615,807	11,928	252,958	692,371	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.850489	8.497289	2.240842	0.584820	9.223005	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	130,004	8,326	161	27,976	15,783	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.694150	0.114887	0.030246	0.064678	0.210244	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATION (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
			10.00	11.00	13.00	14.00	15.00	
		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
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	76,886					10.00
11.00	01100	CAFETERIA	0	13,582				11.00
13.00	01300	NURSING ADMINISTRATION	0	700	4,912			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	215	0	944,465		14.00
15.00	01500	PHARMACY	0	251	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	594	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,458	1,729	1,729	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	476	367	367	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	62,048	3,602	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	645	645	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	806	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	1,085	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	394	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	534	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	72	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	36	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	785,874	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	158,591	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	309	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	119	0	0	88.01
90.00	09000	CLINIC	3,904	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	1,587	1,587	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	156	156	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,886	12,773	4,912	944,465	100	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	809	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	766,688	232,135	480,148	198,295	516,442	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.971750	17.091371	97.750000	0.209955	5,164.420000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,672	25,382	13,400	9,347	28,435	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.359909	1.868797	2.728013	0.009897	284.350000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet B-1 | Date/Time Prepared: 5/21/2014 2:21 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY				7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,385,541			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,853,110			30.00
31.00	03100	INTENSIVE CARE UNIT	262,064			31.00
44.00	04400	SKILLED NURSING FACILITY	3,436,704			44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,120,174	0		50.00
53.00	05300	ANESTHESIOLOGY	3,087	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,417,967	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	720,812	0		55.00
60.00	06000	LABORATORY	11,650,226	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,161,885	0		65.00
66.00	06600	PHYSICAL THERAPY	1,554,293	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	226,061	0		67.00
68.00	06800	SPEECH PATHOLOGY	36,470	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,694,395	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	167,129	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,587,386	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	118,994	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	70,082	0		88.01
90.00	09000	CLINIC	2,196,981	0		90.00
90.01	09002	WOUND CARE	92,064	0		90.01
91.00	09100	EMERGENCY	6,870,432	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,401,501	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,641,817	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,743,724	0		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		192.01
192.02	19202	PUBLIC RELATIONS	0	0		192.02
192.03	19203	PERSONAL LAUNDRY	0	0		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0		192.04
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	648,429	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010738	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,450	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000819	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/21/2014 2:21 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	2,229,714		2,229,714	0	2,229,714	30.00
31.00	03100	INTENSIVE CARE UNIT	417,740		417,740	0	417,740	31.00
44.00	04400	SKILLED NURSING FACILITY	3,842,000		3,842,000	0	3,842,000	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,253,166		1,253,166	0	1,253,166	50.00
53.00	05300	ANESTHESIOLOGY	4,097		4,097	0	4,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,939,032		1,939,032	0	1,939,032	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	210,580		210,580	0	210,580	55.00
60.00	06000	LABORATORY	1,851,160		1,851,160	0	1,851,160	60.00
65.00	06500	RESPIRATORY THERAPY	569,101	0	569,101	0	569,101	65.00
66.00	06600	PHYSICAL THERAPY	692,959	0	692,959	0	692,959	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,090	0	122,090	0	122,090	67.00
68.00	06800	SPEECH PATHOLOGY	54,070	0	54,070	0	54,070	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,650		971,650	0	971,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	222,296		222,296	0	222,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,484,641		1,484,641	0	1,484,641	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	487,845		487,845	0	487,845	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	152,199		152,199	0	152,199	88.01
90.00	09000	CLINIC	924,134		924,134	0	924,134	90.00
90.01	09002	WOUND CARE	30,145		30,145	0	30,145	90.01
91.00	09100	EMERGENCY	2,083,937		2,083,937	0	2,083,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	348,233		348,233		348,233	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	272,807		272,807	0	272,807	95.00
200.00		Subtotal (see instructions)	20,163,596	0	20,163,596	0	20,163,596	200.00
201.00		Less Observation Beds	348,233		348,233		348,233	201.00
202.00		Total (see instructions)	19,815,363	0	19,815,363	0	19,815,363	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/21/2014 2:21 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	2,647,558		2,647,558			30.00
31.00	03100	INTENSIVE CARE UNIT	262,064		262,064			31.00
44.00	04400	SKILLED NURSING FACILITY	3,436,704		3,436,704			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,443	2,034,732	2,120,175	0.591067	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,372	1,715	3,087	1.327178	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	632,840	10,785,128	11,417,968	0.169823	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	67,947	652,865	720,812	0.292143	0.000000	55.00
60.00	06000	LABORATORY	1,544,822	10,105,404	11,650,226	0.158895	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	822,304	1,339,581	2,161,885	0.263243	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	508,342	1,045,951	1,554,293	0.445836	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,468	104,593	226,061	0.540075	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,642	21,828	36,470	1.482588	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,505,544	1,188,851	2,694,395	0.360619	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	101,298	65,831	167,129	1.330086	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,136,664	3,450,722	6,587,386	0.225376	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	118,994	118,994			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	70,082	70,082			88.01
90.00	09000	CLINIC	0	2,196,981	2,196,981	0.420638	0.000000	90.00
90.01	09002	WOUND CARE	0	92,064	92,064	0.327435	0.000000	90.01
91.00	09100	EMERGENCY	165,333	6,705,099	6,870,432	0.303320	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	75,337	1,222,057	1,297,394	0.268410	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,401,501	1,401,501	0.194653	0.000000	95.00
200.00		Subtotal (see instructions)	15,129,682	42,603,979	57,733,661			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,129,682	42,603,979	57,733,661			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/21/2014 2:21 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
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 (RHC) VANDALIA			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09002	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,229,714		2,229,714	0	2,229,714	30.00
31.00	03100	INTENSIVE CARE UNIT	417,740		417,740	0	417,740	31.00
44.00	04400	SKILLED NURSING FACILITY	3,842,000		3,842,000	0	3,842,000	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,253,166		1,253,166	0	1,253,166	50.00
53.00	05300	ANESTHESIOLOGY	4,097		4,097	0	4,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,939,032		1,939,032	0	1,939,032	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	210,580		210,580	0	210,580	55.00
60.00	06000	LABORATORY	1,851,160		1,851,160	0	1,851,160	60.00
65.00	06500	RESPIRATORY THERAPY	569,101	0	569,101	0	569,101	65.00
66.00	06600	PHYSICAL THERAPY	692,959	0	692,959	0	692,959	66.00
67.00	06700	OCCUPATIONAL THERAPY	122,090	0	122,090	0	122,090	67.00
68.00	06800	SPEECH PATHOLOGY	54,070	0	54,070	0	54,070	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	971,650		971,650	0	971,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	222,296		222,296	0	222,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,484,641		1,484,641	0	1,484,641	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	487,845		487,845	0	487,845	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	152,199		152,199	0	152,199	88.01
90.00	09000	CLINIC	924,134		924,134	0	924,134	90.00
90.01	09002	WOUND CARE	30,145		30,145	0	30,145	90.01
91.00	09100	EMERGENCY	2,083,937		2,083,937	0	2,083,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	348,233		348,233		348,233	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	272,807		272,807	0	272,807	95.00
200.00		Subtotal (see instructions)	20,163,596	0	20,163,596	0	20,163,596	200.00
201.00		Less Observation Beds	348,233		348,233		348,233	201.00
202.00		Total (see instructions)	19,815,363	0	19,815,363	0	19,815,363	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,647,558		2,647,558			30.00
31.00	03100	INTENSIVE CARE UNIT	262,064		262,064			31.00
44.00	04400	SKILLED NURSING FACILITY	3,436,704		3,436,704			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,443	2,034,732	2,120,175	0.591067	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,372	1,715	3,087	1.327178	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	632,840	10,785,128	11,417,968	0.169823	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	67,947	652,865	720,812	0.292143	0.000000	55.00
60.00	06000	LABORATORY	1,544,822	10,105,404	11,650,226	0.158895	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	822,304	1,339,581	2,161,885	0.263243	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	508,342	1,045,951	1,554,293	0.445836	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,468	104,593	226,061	0.540075	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,642	21,828	36,470	1.482588	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,505,544	1,188,851	2,694,395	0.360619	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	101,298	65,831	167,129	1.330086	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,136,664	3,450,722	6,587,386	0.225376	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	118,994	118,994	4.099745	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	70,082	70,082	2.171727	0.000000	88.01
90.00	09000	CLINIC	0	2,196,981	2,196,981	0.420638	0.000000	90.00
90.01	09002	WOUND CARE	0	92,064	92,064	0.327435	0.000000	90.01
91.00	09100	EMERGENCY	165,333	6,705,099	6,870,432	0.303320	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	75,337	1,222,057	1,297,394	0.268410	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,401,501	1,401,501	0.194653	0.000000	95.00
200.00		Subtotal (see instructions)	15,129,682	42,603,979	57,733,661			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,129,682	42,603,979	57,733,661			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet C Part I Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
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 (RHC) VANDALIA	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09002	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part II Date/Time Prepared: 5/21/2014 2:21 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	98,606	2,120,175	0.046508	79,003	3,674	50.00
53.00	05300	ANESTHESIOLOGY	58	3,087	0.018788	1,029	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,370	11,417,968	0.014834	224,530	3,331	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,332	720,812	0.004623	53,607	248	55.00
60.00	06000	LABORATORY	70,892	11,650,226	0.006085	867,668	5,280	60.00
65.00	06500	RESPIRATORY THERAPY	68,757	2,161,885	0.031804	519,506	16,522	65.00
66.00	06600	PHYSICAL THERAPY	56,680	1,554,293	0.036467	80,122	2,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,917	226,061	0.030598	16,718	512	67.00
68.00	06800	SPEECH PATHOLOGY	2,820	36,470	0.077324	4,041	312	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,499	2,694,395	0.007608	1,040,058	7,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,238	167,129	0.025358	76,255	1,934	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,964	6,587,386	0.006978	1,385,149	9,666	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	7,341	118,994	0.061692	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	2,342	70,082	0.033418	0	0	88.01
90.00	09000	CLINIC	70,902	2,196,981	0.032272	0	0	90.00
90.01	09002	WOUND CARE	469	92,064	0.005094	0	0	90.01
91.00	09100	EMERGENCY	78,801	6,870,432	0.011470	913	10	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,297,394	0.000000	1,040	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	707,988	49,985,834		4,349,639	52,343	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/21/2014 2:21 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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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 (RHC) VANDALIA	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV Date/Time Prepared: 5/21/2014 2:21 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	2,120,175	0.000000	0.000000	79,003	50.00
53.00	05300	ANESTHESIOLOGY	0	3,087	0.000000	0.000000	1,029	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,417,968	0.000000	0.000000	224,530	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	720,812	0.000000	0.000000	53,607	55.00
60.00	06000	LABORATORY	0	11,650,226	0.000000	0.000000	867,668	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,161,885	0.000000	0.000000	519,506	65.00
66.00	06600	PHYSICAL THERAPY	0	1,554,293	0.000000	0.000000	80,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	226,061	0.000000	0.000000	16,718	67.00
68.00	06800	SPEECH PATHOLOGY	0	36,470	0.000000	0.000000	4,041	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,694,395	0.000000	0.000000	1,040,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	167,129	0.000000	0.000000	76,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,587,386	0.000000	0.000000	1,385,149	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	118,994	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	70,082	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	2,196,981	0.000000	0.000000	0	90.00
90.01	09002	WOUND CARE	0	92,064	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,870,432	0.000000	0.000000	913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,297,394	0.000000	0.000000	1,040	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	49,985,834			4,349,639	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/21/2014 2:21 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	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
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 (RHC) VANDALIA	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
90.01	09002	WOUND CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/21/2014 2:21 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	0.591067	0	1,095,454	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.327178	0	1,372	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169823	0	4,570,446	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.292143	0	490,195	0	0	55.00
60.00	06000	LABORATORY	0.158895	0	5,711,027	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.263243	0	934,486	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445836	0	479,926	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.540075	0	22,688	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.482588	0	4,263	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.360619	0	364,563	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.330086	0	49,588	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225376	0	2,733,543	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000				0	88.01
90.00	09000	CLINIC	0.420638	0	2,023,077	0	0	90.00
90.01	09002	WOUND CARE	0.327435	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.303320	0	1,857,856	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268410	0	294,594	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.194653		0			95.00
200.00		Subtotal (see instructions)		0	20,633,078	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	20,633,078	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/21/2014 2:21 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	647,487	0		50.00
53.00	05300	ANESTHESIOLOGY	1,821	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	776,167	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	143,207	0		55.00
60.00	06000	LABORATORY	907,454	0		60.00
65.00	06500	RESPIRATORY THERAPY	245,997	0		65.00
66.00	06600	PHYSICAL THERAPY	213,968	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,253	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,320	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,468	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,956	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	616,075	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0		88.01
90.00	09000	CLINIC	850,983	0		90.00
90.01	09002	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	563,525	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	79,072	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,261,753	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,261,753	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/21/2014 2:21 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	0.591067	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.327178	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169823	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.292143	0	0	0	0	55.00
60.00	06000	LABORATORY	0.158895	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.263243	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445836	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.540075	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.482588	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.360619	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.330086	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225376	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000				0	88.01
90.00	09000	CLINIC	0.420638	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.327435	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.303320	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268410	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.194653		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: 141346 | Component CCN: 14Z346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V | Date/Time Prepared: 5/21/2014 2:21 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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 (RHC) VANDALIA	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09002	WOUND CARE	0	0		90.01
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 INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/21/2014 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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 (RHC) VANDALIA	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/21/2014 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,120,175	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,087	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,417,968	0.000000	0.000000	21,650	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	720,812	0.000000	0.000000	0	55.00
60.00	06000	LABORATORY	0	11,650,226	0.000000	0.000000	83,309	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,161,885	0.000000	0.000000	1,658	65.00
66.00	06600	PHYSICAL THERAPY	0	1,554,293	0.000000	0.000000	175,431	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	226,061	0.000000	0.000000	61,665	67.00
68.00	06800	SPEECH PATHOLOGY	0	36,470	0.000000	0.000000	3,986	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,694,395	0.000000	0.000000	107,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	167,129	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,587,386	0.000000	0.000000	448,493	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	118,994	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	70,082	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	2,196,981	0.000000	0.000000	0	90.00
90.01	09002	WOUND CARE	0	92,064	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,870,432	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,297,394	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	49,985,834			903,882	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part IV | Date/Time Prepared: 5/21/2014 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
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 (RHC) VANDALIA	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
90.01	09002	WOUND CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.591067	0	245,453	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.327178	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169823	0	2,217,097	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.292143	0	86,376	0	0	55.00
60.00	06000	LABORATORY	0.158895	0	1,336,520	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.263243	0	90,233	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445836	0	177,804	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.540075	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.482588	0	307	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.360619	0	175,913	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.330086	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225376	0	474,921	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	4.099745				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	2.171727				0	88.01
90.00	09000	CLINIC	0.420638	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.327435	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.303320	0	1,963,402	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268410	0	86,058	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.194653	0	0			95.00
200.00		Subtotal (see instructions)		0	6,854,084	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	6,854,084	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D Part V Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	145,079	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	376,514	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	25,234	0		55.00
60.00	06000	LABORATORY	212,366	0		60.00
65.00	06500	RESPIRATORY THERAPY	23,753	0		65.00
66.00	06600	PHYSICAL THERAPY	79,271	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	455	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,438	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,036	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09002	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	595,539	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,099	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,651,784	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,651,784	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/21/2014 2:21 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)	3,807	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,424	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,840	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,289	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	94	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)	1,461	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)	1,289	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	166.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,229,714	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)	15,679	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)	784,297	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,445,417	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,445,417	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)	596.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	871,180	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)	871,180	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/21/2014 2:21 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	417,740	197	2,120.51	143	303,233	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,216,444	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,390,857	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)	768,618	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)	768,618	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)	584	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	596.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	348,233	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/21/2014 2:21 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: 141346 Component CCN: 145499	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/21/2014 2:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,849	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,849	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)	20,849	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	897	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	166.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,842,000	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,842,000	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)	3,842,000	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/21/2014 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	3,842,000	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	184.28	71.00
72.00	Program routine service cost (line 9 x line 71)	165,299	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	165,299	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	165,299	83.00
84.00	Program inpatient ancillary services (see instructions)	274,692	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	439,991	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1

Component CCN: 145499 | Date/Time Prepared: 5/21/2014 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,807	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,424	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,840	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,383	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	94	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)	147	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	166.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,229,714	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)	15,679	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)	819,990	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,409,724	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,409,724	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)	581.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	85,491	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)	85,491	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	417,740	197	2,120.51	0	0	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)	140,935	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	226,426	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	584	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	581.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	339,637	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-1 | Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/21/2014 2:21 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		1,349,265		30.00
31.00	03100	INTENSIVE CARE UNIT		212,927		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.591067	79,003	46,696	50.00
53.00	05300	ANESTHESIOLOGY	1.327178	1,029	1,366	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169823	224,530	38,130	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.292143	53,607	15,661	55.00
60.00	06000	LABORATORY	0.158895	867,668	137,868	60.00
65.00	06500	RESPIRATORY THERAPY	0.263243	519,506	136,756	65.00
66.00	06600	PHYSICAL THERAPY	0.445836	80,122	35,721	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.540075	16,718	9,029	67.00
68.00	06800	SPEECH PATHOLOGY	1.482588	4,041	5,991	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.360619	1,040,058	375,065	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.330086	76,255	101,426	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225376	1,385,149	312,179	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000		0	88.01
90.00	09000	CLINIC	0.420638	0	0	90.00
90.01	09002	WOUND CARE	0.327435	0	0	90.01
91.00	09100	EMERGENCY	0.303320	913	277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268410	1,040	279	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		4,349,639	1,216,444	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)		4,349,639		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/21/2014 2:21 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	0.591067	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.327178	343	455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169823	63,390	10,765	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.292143	6,452	1,885	55.00
60.00	06000	LABORATORY	0.158895	195,188	31,014	60.00
65.00	06500	RESPIRATORY THERAPY	0.263243	169,661	44,662	65.00
66.00	06600	PHYSICAL THERAPY	0.445836	200,515	89,397	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.540075	28,076	15,163	67.00
68.00	06800	SPEECH PATHOLOGY	1.482588	6,361	9,431	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.360619	189,037	68,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.330086	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225376	806,491	181,764	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000		0	88.01
90.00	09000	CLINIC	0.420638	0	0	90.00
90.01	09002	WOUND CARE	0.327435	0	0	90.01
91.00	09100	EMERGENCY	0.303320	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268410	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)		1,665,514	452,706	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,665,514		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3

Component CCN: 145499 | Date/Time Prepared: 5/21/2014 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.591067	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.327178	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169823	21,650	3,677	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.292143	0	0	55.00
60.00	06000	LABORATORY	0.158895	83,309	13,237	60.00
65.00	06500	RESPIRATORY THERAPY	0.263243	1,658	436	65.00
66.00	06600	PHYSICAL THERAPY	0.445836	175,431	78,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.540075	61,665	33,304	67.00
68.00	06800	SPEECH PATHOLOGY	1.482588	3,986	5,910	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.360619	107,690	38,835	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.330086	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225376	448,493	101,080	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000		0	88.01
90.00	09000	CLINIC	0.420638	0	0	90.00
90.01	09002	WOUND CARE	0.327435	0	0	90.01
91.00	09100	EMERGENCY	0.303320	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268410	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)		903,882	274,692	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)		903,882		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet D-3 | Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		177,665		30.00
31.00	03100	INTENSIVE CARE UNIT		19,852		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.591067	6,440	3,806	50.00
53.00	05300	ANESTHESIOLOGY	1.327178	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169823	80,395	13,653	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.292143	7,888	2,304	55.00
60.00	06000	LABORATORY	0.158895	136,806	21,738	60.00
65.00	06500	RESPIRATORY THERAPY	0.263243	114,545	30,153	65.00
66.00	06600	PHYSICAL THERAPY	0.445836	3,188	1,421	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.540075	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.482588	254	377	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.360619	12,148	4,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.330086	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225376	179,858	40,536	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	4.099745	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	2.171727	0	0	88.01
90.00	09000	CLINIC	0.420638	0	0	90.00
90.01	09002	WOUND CARE	0.327435	0	0	90.01
91.00	09100	EMERGENCY	0.303320	53,072	16,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268410	24,099	6,468	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		618,693	140,935	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)		618,693		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/21/2014 2:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,261,753	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)	5,261,753	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)	5,314,371	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)	39,373	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,986,284	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,288,714	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,288,714	30.00
31.00	Primary payer payments	1,594	31.00
32.00	Subtotal (line 30 minus line 31)	2,287,120	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)	850,114	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	748,100	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	779,569	36.00
37.00	Subtotal (see instructions)	3,035,220	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)	3,035,220	40.00
40.01	Sequestration adjustment (see instructions)	45,832	40.01
41.00	Interim payments	3,519,537	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-530,149	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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2014 2:21 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		1,918,907		3,519,537	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,918,907		3,519,537	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		143,370		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		530,149	6.02
7.00	Total Medicare program liability (see instructions)		2,062,277		2,989,388	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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2014 2:21 pm

Component CCN: 14Z346 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,156,720		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/26/2013	62,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		62,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,218,720		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		29,756		0	6.02
7.00	Total Medicare program liability (see instructions)		1,188,964		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141346	Period:	Worksheet E-1
Component CCN: 145499	From 01/01/2013 To 12/31/2013	Part I Date/Time Prepared: 5/21/2014 2:21 pm
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		250,665		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		250,665		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		7,906		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		258,571		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: 141346	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/21/2014 2:21 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	628	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,604	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	4	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,037	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	57,733,661	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	539,019	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	132,184	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	131,761	8.00
9.00	Sequestration adjustment amount (see instructions)	2,635	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	129,126	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)	129,126	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-2 | Date/Time Prepared: 5/21/2014 2:21 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)	776,304	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)	457,233	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	1,289	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,233,537	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,233,537	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,233,537	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	26,344	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,207,193	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,207,193	0	19.00
19.01	Sequestration adjustment (see instructions)	18,229	0	19.01
20.00	Interim payments	1,218,720	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	-29,756	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: 141346	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/21/2014 2:21 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	2,390,857	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,390,857	4.00
5.00	Primary payer payments	3,285	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,411,481	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,411,481	19.00
20.00	Deductibles (exclude professional component)	381,399	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,030,082	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,030,082	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	72,515	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	63,813	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	66,431	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,093,895	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,093,895	30.00
30.01	Sequestration adjustment (see instructions)	31,618	30.01
31.00	Interim payments	1,918,907	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	143,370	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346 Component CCN: 145499	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VI Date/Time Prepared: 5/21/2014 2:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	308,878	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	308,878	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	54,464	7.00
8.00	Allowable bad debts (see instructions)	12,494	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	8,121	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	262,535	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	262,535	15.00
15.01	Sequestration adjustment (see instructions)	3,964	15.01
16.00	Interim payments	250,665	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	7,906	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet E-3 Part VII | Date/Time Prepared: 5/21/2014 2:21 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	226,426		1.00
2.00	Medical and other services		1,651,784	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	226,426	1,651,784	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	226,426	1,651,784	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	618,693	6,854,084	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	618,693	6,854,084	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	618,693	6,854,084	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	392,267	5,202,300	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	226,426	1,651,784	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	226,426	1,651,784	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	226,426	1,651,784	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	226,426	1,651,784	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	226,426	1,651,784	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	226,426	1,651,784	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	226,426	1,651,784	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346 Component CCN: 145499	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/21/2014 2:21 pm
	Title XIX	Skilled Nursing Facility	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G | Date/Time Prepared: 5/21/2014 2:21 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	4,099,194	0	0	0	1.00
2.00	Temporary investments	997,333	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,557,760	0	0	0	4.00
5.00	Other receivable	720,692	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,170,410	0	0	0	6.00
7.00	Inventory	240,813	0	0	0	7.00
8.00	Prepaid expenses	692,147	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	16,667	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,154,196	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	27,359,543	0	0	0	19.00
20.00	Accumulated depreciation	-18,194,923	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)	9,164,620	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	3,968	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,968	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,322,784	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	652,243	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,081,072	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,614,588	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,347,903	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,347,903	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,974,881				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)	15,974,881	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,322,784	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-1 | Date/Time Prepared: 5/21/2014 2:21 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		15,196,135		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,735,167				2.00
3.00	Total (sum of line 1 and line 2)		17,931,302		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)		17,931,302		0		11.00
12.00	Deductions	1,956,421		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)		1,956,421		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,974,881		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		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: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/21/2014 2:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,858,429		2,858,429	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	3,250,342		3,250,342	6.00
7.00	SKILLED NURSING FACILITY	186,362		186,362	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)	6,295,133		6,295,133	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	262,064		262,064	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)	262,064		262,064	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,557,197		6,557,197	17.00
18.00	Ancillary services	8,835,475	0	8,835,475	18.00
19.00	Outpatient services	0	41,870,375	41,870,375	19.00
20.00	RURAL HEALTH CLINIC (RHC) VANDALIA	0	118,994	118,994	20.00
20.01	RURAL HEALTH CLINIC (RHC) ST ELMO	0	70,082	70,082	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,401,501	1,401,501	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	312,707	1,938,275	2,250,982	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,705,379	45,399,227	61,104,606	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,864,330		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	MEDICAID TAX ASSESSMENT	185,292			37.00
38.00	PHYSICIAN EXPENSE	2,652,711			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)		2,838,003		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,026,327		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141346	Period: From 01/01/2013 To 12/31/2013	Worksheet G-3 Date/Time Prepared: 5/21/2014 2:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	61,104,606	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,947,493	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,157,113	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,026,327	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,130,786	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 REVENUE	1,072,722	24.00
25.00	Total other income (sum of lines 6-24)	1,072,722	25.00
26.00	Total (line 5 plus line 25)	2,203,508	26.00
27.00	OTHER EXPENSES	-531,659	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-531,659	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,735,167	29.00

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

Provider CCN: 141346 Component CCN: 148527 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/21/2014 2:21 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	136,921	0	136,921	0	136,921	1.00
2.00	Physician Assistant	39,544	0	39,544	0	39,544	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	78,512	0	78,512	0	78,512	9.00
10.00	Subtotal (sum of lines 1-9)	254,977	0	254,977	0	254,977	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	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	63,841	63,841	0	63,841	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	63,841	63,841	0	63,841	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	254,977	63,841	318,818	0	318,818	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	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	254,977	63,841	318,818	0	318,818	32.00

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

Provider CCN: 141346 Component CCN: 148527 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/21/2014 2:21 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	136,921		1.00
2.00	Physician Assistant	0	39,544		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	78,512		9.00
10.00	Subtotal (sum of lines 1-9)	0	254,977		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	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	63,841		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	63,841		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	318,818		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	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	318,818		32.00

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

Provider CCN: 141346 Component CCN: 148528 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/21/2014 2:21 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	27,651	0	27,651	0	27,651	1.00
2.00	Physician Assistant	28,144	0	28,144	0	28,144	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	21,531	0	21,531	0	21,531	9.00
10.00	Subtotal (sum of lines 1-9)	77,326	0	77,326	0	77,326	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	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	20,559	20,559	0	20,559	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	20,559	20,559	0	20,559	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	77,326	20,559	97,885	0	97,885	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	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	77,326	20,559	97,885	0	97,885	32.00

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

Provider CCN: 141346 | Component CCN: 148528 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-1 | Date/Time Prepared: 5/21/2014 2:21 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	27,651		1.00
2.00	Physician Assistant	0	28,144		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	21,531		9.00
10.00	Subtotal (sum of lines 1-9)	0	77,326		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	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	20,559		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	20,559		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	97,885		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	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	97,885		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141346 | Component CCN: 148527 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2 | Date/Time Prepared: 5/21/2014 2:21 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	0.54	959	4,200	2,268		1.00
2.00	Physician Assistant	0.33	854	2,100	693		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	0.87	1,813		2,961	2,961	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.87	1,813			2,961	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)					318,818	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)					318,818	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)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					169,027	15.00
16.00	Total overhead (sum of lines 14 and 15)					169,027	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					169,027	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					169,027	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					487,845	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141346 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-2

Component CCN: 148528 | Date/Time Prepared: 5/21/2014 2:21 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.12	232	4,200	504		1.00
2.00	Physician Assistant	0.23	836	2,100	483		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	0.35	1,068		987	1,068	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.35	1,068			1,068	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)					97,885	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)					97,885	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)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					54,314	15.00
16.00	Total overhead (sum of lines 14 and 15)					54,314	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					54,314	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					54,314	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					152,199	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141346 Component CCN: 148527	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3 Date/Time Prepared: 5/21/2014 2:21 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)		487,845	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)		487,845	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,961	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,961	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		164.76	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)	164.76	164.76	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	585	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	96,385	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) *		96,385	16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,735	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.)		75,194	16.04
16.05	Total program cost (see instructions)		75,194	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,392	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		75,194	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)		75,194	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)		75,194	26.00
26.01	Sequestration adjustment (see instructions)		1,135	26.01
27.00	Interim payments		34,418	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		39,641	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141346 Component CCN: 148528	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3 Date/Time Prepared: 5/21/2014 2:21 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		152,199	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)		152,199	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,068	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,068	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		142.51	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)	142.51	142.51	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	232	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	33,062	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) *		33,062	16.00
16.01	Total program charges (see instructions)(from contractor's records)		16,907	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.)		25,456	16.04
16.05	Total program cost (see instructions)		25,456	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,242	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		25,456	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)		25,456	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)		25,456	26.00
26.01	Sequestration adjustment (see instructions)		384	26.01
27.00	Interim payments		13,426	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		11,646	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: 141346 | Component CCN: 148527 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 5/21/2014 2:21 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		34,418	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)		34,418	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		39,641	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		74,059	7.00

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

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

Provider CCN: 141346 | Component CCN: 148528 | Period: From 01/01/2013 To 12/31/2013 | Worksheet M-5 | Date/Time Prepared: 5/21/2014 2:21 pm

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		13,426	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)		13,426	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		11,646	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		25,072	7.00

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