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: 141317	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/24/2015 4:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/24/2015 Time: 4:26 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 GIBSON AREA HOSPITAL AND HEALTH SVCS (141317) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 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	1,024,885	-634,789	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	162,487	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-3		0	7.00
10.00	RHC - PAXTON CLINIC I	0		411,755		0	10.00
10.01	RHC II -ONARGA CLINIC	0		52,076		0	10.01
10.02	RHC III - FORREST CLINIC	0		84,143		0	10.02
10.03	RHC IV - HOOPESTON	0		36,090		0	10.03
10.04	RHC V - FARMER CITY	0		62,687		0	10.04
10.05	RHC VI - GIBSON CITY	0		21,898		0	10.05
200.00	Total	0	1,187,372	33,857	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2015 4:07 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1120 N. MELVIN	PO Box:			1.00
2.00	City: GIBSON CITY	State: IL	Zip Code: 60936-	County: FORD	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	GIBSON AREA HOSPITAL AND HEALTH SVCS	141317	99914	1	01/03/2002	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GIBSON COMMUNITY SWING BEDS	14Z317	99914		12/31/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GIBSON HOSPITAL ANNEX SNF	145979	99914		05/19/1999	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	MED CLINIC OF EAST CENTRAL ILLINOIS	143408	99914		01/01/1996	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	THE ONARGA CLINIC	143440	99914		10/01/1998	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	PRAIRIE FAMILY MEDICINE & OBSTETRI	148505	99914		06/30/2009	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	HOOPESTON CLINIC	148515	99914		08/11/2011	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	FARMER CITY CLINIC	148517	99914		09/16/2011	N	N	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	GIBSON CITY CLINIC	148516	99914		09/22/2011	N	N	N	15.05
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	09/30/2014	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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2015 4:07 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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2015 4:07 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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2015 4:07 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 an approved GME 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 an approved GME 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	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

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		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	711,474	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2015 4:07 pm

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	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)	10/01/2013	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2015 4:07 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	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	01/17/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2015 4:07 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.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2015 4:07 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)				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)	01/17/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/24/2015 4:07 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	23	8,395	59,832.00	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)		23	8,395	59,832.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	1,728.00	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	61,560.00	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	5	1,825		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	37	13,505			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	RHC - PAXTON CLINIC	88.00				0	26.00
26.01	RHC II -ONARGA CLINIC	88.01				0	26.01
26.02	RHC III - FORREST CLINIC	88.02				0	26.02
26.03	RHC IV - HOOPESTON	88.03				0	26.03
26.04	RHC V - FARMER CITY	88.04				0	26.04
26.05	RHC VI - GIBSON CITY	88.05				0	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		67				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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2015 4:07 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)	1,272	382	2,493			1.00
2.00	HMO and other (see instructions)	291	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	522	0	691			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	119			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,794	382	3,303			7.00
8.00	INTENSIVE CARE UNIT	59	1	72			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		0	293			13.00
14.00	Total (see instructions)	1,853	383	3,668	0.00	442.22	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	569	0	618	0.00	1.70	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			11,887	0.00	32.65	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	RHC - PAXTON CLINIC	4,847	0	15,702	0.00	31.43	26.00
26.01	RHC II -ONARGA CLINIC	419	0	3,464	0.00	8.80	26.01
26.02	RHC III - FORREST CLINIC	614	0	3,883	0.00	12.57	26.02
26.03	RHC IV - HOOPESTON	531	0	2,732	0.00	7.81	26.03
26.04	RHC V - FARMER CITY	493	0	2,312	0.00	5.21	26.04
26.05	RHC VI - GIBSON CITY	201	0	3,327	0.00	5.20	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	547.59	27.00
28.00	Observation Bed Days		0	358			28.00
29.00	Ambulance Trips	945					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	88			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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2015 4:07 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	375	155	864	1.00
2.00	HMO and other (see instructions)			66	0		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	375	155	864	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	0.00				51	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	RHC - PAXTON CLINIC	0.00					26.00
26.01	RHC II -ONARGA CLINIC	0.00					26.01
26.02	RHC III - FORREST CLINIC	0.00					26.02
26.03	RHC IV - HOOPESTON	0.00					26.03
26.04	RHC V - FARMER CITY	0.00					26.04
26.05	RHC VI - GIBSON CITY	0.00					26.05
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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-7 | Date/Time Prepared: 2/24/2015 4:07 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	12/31/2002	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	15	0	15	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	14	0	14	14.00
15.00		RVC	36	0	36	15.00
16.00		RVB	102	0	102	16.00
17.00		RVA	141	0	141	17.00
18.00		RHC	18	0	18	18.00
19.00		RHB	98	0	98	19.00
20.00		RHA	91	0	91	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	27	0	27	22.00
23.00		RMA	19	0	19	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	4	0	4	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	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	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	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	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	0	0	0	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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-7 | Date/Time Prepared: 2/24/2015 4:07 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	4	0	4	199.00
200.00	TOTAL		569	0	569	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).	16580	16580	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	73,453	44.76	Y	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)	164,088			207.00

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

Provider CCN: 141317 Component CCN: 143408 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 | Date/Time Prepared: 2/24/2015 4:07 pm

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			225 MARKET STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	PAXTON		IL	60957	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			07:00	17:00	07:00	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		FORD				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	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/24/2015 4:07 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	07:00	17:00				11.00

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

Provider CCN: 141317 Component CCN: 143440 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 Date/Time Prepared: 2/24/2015 4:07 pm

		Rural Health Clinic (RHC) II	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	109 NORTH CHESNUT		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	ONARGA	IL	60955 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:00	07:00	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		IROGUOIS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	07:00	19:00	07:00	19:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141317 Component CCN: 143440	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/24/2015 4:07 pm
		Rural Health Clinic (RHC) II	Cost

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

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

Provider CCN: 141317 Component CCN: 148505 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 | Date/Time Prepared: 2/24/2015 4:07 pm

					Rural Health Clinic (RHC) III	Cost	
					1.00		
	Clinic Address and Identification						
1.00	Street				122 EAST WABASH AVENUE		1.00
			City		State	Zip Code	
			1.00		2.00	3.00	
2.00	City, State, Zip Code, County		FORREST		IL	61741-0058	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			07:30	17:00	07:30	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	Provider name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00
			County				
			4.00				
2.00	City, State, Zip Code, County		LIVINGSTON				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	07:30	17:00	07:30	17:00	11.00

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

Provider CCN: 141317
Component CCN: 148505

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-8

Date/Time Prepared:
2/24/2015 4:07 pm

Rural Health Clinic (RHC) III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	17:00				11.00

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

Provider CCN: 141317 Component CCN: 148515 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) IV | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			837 E ORANGE STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	HOOPESTON		IL	60942	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			08:30	18:00	08:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, Zip Code, County		VERMILLION				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	08:30	13:00	08:30	15:00	11.00

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

Provider CCN: 141317
Component CCN: 148515

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-8

Date/Time Prepared:
2/24/2015 4:07 pm

Rural Health Clinic (RHC) IV

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:30	15:00				11.00

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

Provider CCN: 141317 Component CCN: 148517 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) V

				1.00		
	Clinic Address and Identification					
1.00	Street			1230 GEORGE ROCK DR		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	FARMER CITY		IL	61842	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			08:30	17:00	08:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, Zip Code, County						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	08:30	12:00	08:30	15:00	11.00

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

Provider CCN: 141317
Component CCN: 148517

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-8

Date/Time Prepared:
2/24/2015 4:07 pm

Rural Health Clinic (RHC) V

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:30	15:00				11.00

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

Provider CCN: 141317 Component CCN: 148516 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) VI

				1.00		
	Clinic Address and Identification					
1.00	Street			#7 DOCTORS PARK		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	GIBSON CITY		IL	60936	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	05:00	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						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	05:00	08:00	05:00	08:00	05:00	11.00

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

Provider CCN: 141317
Component CCN: 148516

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-8

Date/Time Prepared:
2/24/2015 4:07 pm

Rural Health Clinic (RHC) VI

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/24/2015 4:07 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)	0.420094	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,254,763	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	684,040	5.00
6.00	Medicaid charges	16,357,561	6.00
7.00	Medicaid cost (line 1 times line 6)	6,871,713	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,932,910	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	105,333	9.00
10.00	Stand-alone SCHIP charges	325,892	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	136,905	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	31,572	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,964,482	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,082,004	608,737	2,690,741	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	874,637	255,727	1,130,364	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)	874,637	255,727	1,130,364	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,467,315	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	318,442	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,148,873	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,322,823	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,453,187	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,417,669	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,252,090	2,252,090	-662,865	1,589,225	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	767,032	767,032	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	282,632	8,263,746	8,546,378	84,691	8,631,069	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,107,774	660,211	1,767,985	0	1,767,985	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	3,300,776	6,187,928	9,488,704	-618,415	8,870,289	5.02
7.00	00700	OPERATION OF PLANT	635,908	1,394,029	2,029,937	9,779	2,039,716	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	119,007	49,491	168,498	0	168,498	8.00
9.00	00900	HOUSEKEEPING	298,559	71,990	370,549	0	370,549	9.00
10.00	01000	DIETARY	451,030	317,139	768,169	-535,229	232,940	10.00
11.00	01100	CAFETERIA	0	0	0	436,248	436,248	11.00
13.00	01300	NURSING ADMINISTRATION	339,300	98,001	437,301	11,468	448,769	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,285	71,285	0	71,285	14.00
15.00	01500	PHARMACY	386,022	114,557	500,579	0	500,579	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	316,989	55,816	372,805	0	372,805	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,838,004	350,828	3,188,832	-616,844	2,571,988	30.00
31.00	03100	INTENSIVE CARE UNIT	579,842	9,473	589,315	0	589,315	31.00
43.00	04300	NURSERY	0	0	0	485,270	485,270	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	81,475	81,475	44.00
46.00	04600	OTHER LONG TERM CARE	1,486,296	257,310	1,743,606	-176,466	1,567,140	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,714,751	867,150	2,581,901	0	2,581,901	50.00
51.00	05100	RECOVERY ROOM	311,321	40,941	352,262	0	352,262	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	156,999	156,999	52.00
53.00	05300	ANESTHESIOLOGY	1,007,764	1,077,500	2,085,264	3,554	2,088,818	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,460,644	2,058,358	3,519,002	-101,018	3,417,984	54.00
56.00	05600	RADIOISOTOPE	0	118,609	118,609	105,111	223,720	56.00
60.00	06000	LABORATORY	771,683	871,434	1,643,117	0	1,643,117	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	146,625	146,625	0	146,625	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	419,517	73,425	492,942	0	492,942	65.00
66.00	06600	PHYSICAL THERAPY	1,459,269	202,078	1,661,347	51,741	1,713,088	66.00
67.00	06700	OCCUPATIONAL THERAPY	152,255	7,937	160,192	0	160,192	67.00
68.00	06800	SPEECH PATHOLOGY	51	58,615	58,666	0	58,666	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,028	13,028	0	13,028	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	841,751	841,751	0	841,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,039,115	3,039,115	0	3,039,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,249,331	1,249,331	0	1,249,331	73.00
73.01	07301	CARDIAC REHAB	85,936	10,209	96,145	0	96,145	73.01
73.02	07302	WOUND CARE	156,643	11,507	168,150	0	168,150	73.02
73.03	07303	SLEEP LAB	81,773	109,568	191,341	0	191,341	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	98,981	98,981	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	2,365,945	1,199,905	3,565,850	208,933	3,774,783	88.00
88.01	08801	RHC II -ONARGA CLINIC	586,393	228,560	814,953	72,544	887,497	88.01
88.02	08802	RHC III - FORREST CLINIC	1,043,973	461,786	1,505,759	65,728	1,571,487	88.02
88.03	08803	RHC IV - HOOPESTON	606,667	245,536	852,203	16,629	868,832	88.03
88.04	08804	RHC V - FARMER CITY	399,511	196,331	595,842	40,135	635,977	88.04
88.05	08805	RHC VI - GIBSON CITY	554,054	243,042	797,096	16,745	813,841	88.05
90.00	09000	CLINIC	259,586	41,933	301,519	0	301,519	90.00
90.01	09001	GERI PSYCH CLINIC	186,735	204,643	391,378	0	391,378	90.01
90.02	09002	ORTHO CLINIC	1,177,572	880,747	2,058,319	-67,188	1,991,131	90.02
91.00	09100	EMERGENCY	1,177,700	1,932,978	3,110,678	0	3,110,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,739,676	314,866	2,054,542	96,033	2,150,575	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,861,558	36,901,402	66,762,960	31,071	66,794,031	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.01	19201	GAH - MSO	179,758	147,717	327,475	0	327,475	192.01
192.02	19202	GAH FOUNDATION	10,654	171,789	182,443	0	182,443	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	3,650	3,650	194.00
194.01	07951	PHYSICIAN OFFICE	564,449	166,478	730,927	-24,398	706,529	194.01
194.02	07952	PHYSICIAN CLINICS	786,239	165,358	951,597	1,538	953,135	194.02
194.03	07953	WELLNESS CENTER	96,173	71,704	167,877	5,429	173,306	194.03
194.04	07954	PSYCH CLINIC	147,356	82,712	230,068	-9,830	220,238	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	30,686	91,507	122,193	12,908	135,101	194.05
194.06	07956	LASER CLINIC	290	6,604	6,894	0	6,894	194.06
194.07	07957	PAIN CLINIC	206	77,842	78,048	0	78,048	194.07
194.08	07958	340B PHARMACY	0	206,795	206,795	0	206,795	194.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/24/2015 4:07 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	
194.09	07959	GAH CARDIOLOGY	377,250	51,689	428,939	-18,797	410,142	194.09
194.10	07960	WIC	100,523	8,345	108,868	0	108,868	194.10
194.11	07961	PULMONARY CLINIC	0	303	303	0	303	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	204,397	135,298	339,695	-1,571	338,124	194.12
200.00		TOTAL (SUM OF LINES 118-199)	32,359,539	38,285,543	70,645,082	0	70,645,082	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-90,548	1,498,677		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-26,855	740,177		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-316,562	8,314,507		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	1,767,985		5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	-1,927,890	6,942,399		5.02
7.00	00700	OPERATION OF PLANT	-5,990	2,033,726		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-67	168,431		8.00
9.00	00900	HOUSEKEEPING	0	370,549		9.00
10.00	01000	DIETARY	0	232,940		10.00
11.00	01100	CAFETERIA	-79,342	356,906		11.00
13.00	01300	NURSING ADMINISTRATION	0	448,769		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,285		14.00
15.00	01500	PHARMACY	0	500,579		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-231	372,574		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,571,988		30.00
31.00	03100	INTENSIVE CARE UNIT	0	589,315		31.00
43.00	04300	NURSERY	0	485,270		43.00
44.00	04400	SKILLED NURSING FACILITY	0	81,475		44.00
46.00	04600	OTHER LONG TERM CARE	0	1,567,140		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-11,400	2,570,501		50.00
51.00	05100	RECOVERY ROOM	0	352,262		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	156,999		52.00
53.00	05300	ANESTHESIOLOGY	-1,839,295	249,523		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-744,401	2,673,583		54.00
56.00	05600	RADIOISOTOPE	0	223,720		56.00
60.00	06000	LABORATORY	-3,300	1,639,817		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	146,625		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	492,942		65.00
66.00	06600	PHYSICAL THERAPY	-44,032	1,669,056		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	160,192		67.00
68.00	06800	SPEECH PATHOLOGY	0	58,666		68.00
69.00	06900	ELECTROCARDIOLOGY	-9,679	3,349		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	841,751		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,039,115		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,249,331		73.00
73.01	07301	CARDIAC REHAB	0	96,145		73.01
73.02	07302	WOUND CARE	0	168,150		73.02
73.03	07303	SLEEP LAB	0	191,341		73.03
73.04	03950	DIETARY EDUCATION	0	98,981		73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - PAXTON CLINIC	-226,761	3,548,022		88.00
88.01	08801	RHC II -ONARGA CLINIC	-3,995	883,502		88.01
88.02	08802	RHC III - FORREST CLINIC	-81,815	1,489,672		88.02
88.03	08803	RHC IV - HOOPESTON	-45,591	823,241		88.03
88.04	08804	RHC V - FARMER CITY	-41,092	594,885		88.04
88.05	08805	RHC VI - GIBSON CITY	-85,136	728,705		88.05
90.00	09000	CLINIC	0	301,519		90.00
90.01	09001	GERI PSYCH CLINIC	-34,050	357,328		90.01
90.02	09002	ORTHO CLINIC	-1,538,376	452,755		90.02
91.00	09100	EMERGENCY	-1,283,704	1,826,974		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,899	2,148,676		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,442,011	58,352,020		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.01	19201	GAH - MSO	0	327,475		192.01
192.02	19202	GAH FOUNDATION	0	182,443		192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	3,650		194.00
194.01	07951	PHYSICIAN OFFICE	-1,200	705,329		194.01
194.02	07952	PHYSICIAN CLINICS	-4,600	948,535		194.02
194.03	07953	WELLNESS CENTER	0	173,306		194.03
194.04	07954	PSYCH CLINIC	0	220,238		194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	-500	134,601		194.05
194.06	07956	LASER CLINIC	0	6,894		194.06
194.07	07957	PAIN CLINIC	-2,500	75,548		194.07
194.08	07958	340B PHARMACY	0	206,795		194.08
194.09	07959	GAH CARDIOLOGY	0	410,142		194.09
194.10	07960	WIC	0	108,868		194.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.11	07961	PULMONARY CLINIC	0	303		194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	338,124		194.12
200.00		TOTAL (SUM OF LINES 118-199)	-8,450,811	62,194,271		200.00

RECLASSIFICATIONS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/24/2015 4:07 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	338,164		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	56,814		2.00
3.00	RHC - PAXTON CLINIC	88.00	0	102,052		3.00
4.00	RHC II -ONARGA CLINIC	88.01	0	11,330		4.00
5.00	RHC III - FORREST CLINIC	88.02	0	46,719		5.00
6.00	AMBULANCE SERVICES	95.00	0	13,122		6.00
7.00	RHC V - FARMER CITY	88.04	0	28,982		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,712		8.00
	TOTALS		0	599,895		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	256,143	180,105		1.00
	TOTALS		256,143	180,105		
	C - OBSTETRICS					
1.00	NURSERY	43.00	435,170	50,100		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	140,790	16,209		2.00
	TOTALS		575,960	66,309		
	D - INTERNAL ALLOC BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	670,838		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	TOTALS		0	670,838		
	E - ADM LONG TERM CARE FEES					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	94,991		1.00
	TOTALS		0	94,991		
	F - SNF DIRECT CARE COST					
1.00	SKILLED NURSING FACILITY	44.00	73,453	8,022		1.00
	TOTALS		73,453	8,022		
	G - BOND AMORT COST					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,045		1.00
	TOTALS		0	2,045		
	H - MME DEPRE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	687,427		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,381		2.00
3.00	PHYSICAL THERAPY	66.00	0	51,741		3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	82,039		4.00
5.00	ANESTHESIOLOGY	53.00	0	3,554		5.00
6.00	RHC - PAXTON CLINIC	88.00	0	119,433		6.00
7.00	RHC III - FORREST CLINIC	88.02	0	12,541		7.00
8.00	RHC IV - HOOPESTON	88.03	0	16,862		8.00
9.00	RHC V - FARMER CITY	88.04	0	16,890		9.00
10.00	RHC VI - GIBSON CITY	88.05	0	17,755		10.00
12.00	ORTHO CLINIC	90.02	0	10,590		12.00
13.00	AMBULANCE SERVICES	95.00	0	54,388		13.00
14.00	HOSPITAL ASSOC SRVCS	194.00	0	3,650		14.00
15.00	PHYSICIAN CLINICS	194.02	0	8,083		15.00
16.00	WELLNESS CENTER	194.03	0	5,429		16.00
17.00	FAMILY HEALTHCARE OF POTOMAC	194.12	0	5,897		17.00
18.00	MAHOMET SPECIALTY CLINIC	194.05	0	13,103		18.00
	TOTALS		0	1,110,763		
	I - CAPITAL INSURANCE EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	105,861		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,746		2.00
	TOTALS		0	126,607		
	J - NUCLEAR MED TECH SALARY					
1.00	RADIOISOTOPE	56.00	105,111	0		1.00
	TOTALS		105,111	0		
	K - AMBULANCE BILLING & UTILITIES COST					
1.00	AMBULANCE SERVICES	95.00	38,302	0		1.00
2.00	OPERATION OF PLANT	7.00	0	9,779		2.00
	TOTALS		38,302	9,779		

RECLASSIFICATIONS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/24/2015 4:07 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	L - PHYSICIAN COSTS				
1.00	ADULTS & PEDIATRICS	30.00	0	25,425	1.00
	TOTALS		0	25,425	
	M - DIETARY EDUCATION				
1.00	DIETARY EDUCATION	73.04	0	98,981	1.00
	TOTALS		0	98,981	
	N - RHC SALARIES				
1.00		0.00	0	0	1.00
	TOTALS		0	0	
	O - RHC PHYSICIAN BENEFITS				
1.00	RHC - PAXTON CLINIC	88.00	0	192,203	1.00
2.00	RHC II -ONARGA CLINIC	88.01	0	61,214	2.00
3.00	RHC III - FORREST CLINIC	88.02	0	76,865	3.00
4.00	RHC IV - HOOPESTON	88.03	0	48,299	4.00
5.00	RHC V - FARMER CITY	88.04	0	44,542	5.00
6.00	RHC VI - GIBSON CITY	88.05	0	28,264	6.00
7.00	ORTHO CLINIC	90.02	0	50,562	7.00
8.00	PHYSICIAN OFFICE	194.01	0	14,670	8.00
9.00	PHYSICIAN CLINICS	194.02	0	26,916	9.00
10.00	PSYCH CLINIC	194.04	0	9,758	10.00
11.00	GAH CARDIOLOGY	194.09	0	13,092	11.00
12.00	FAMILY HEALTHCARE OF POTOMAC	194.12	0	8,294	12.00
13.00	NURSING ADMINISTRATION	13.00	0	11,468	13.00
	TOTALS		0	586,147	
500.00	Grand Total: Increases		1,048,969	3,579,907	500.00

RECLASSIFICATIONS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/24/2015 4:07 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	599,895	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	599,895			
	B - CAFETERIA						
1.00	DIETARY	10.00	256,143	180,105	0		1.00
	TOTALS		256,143	180,105			
	C - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	575,960	66,309	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		575,960	66,309			
	D - INTERNAL ALLOC BENEFITS						
1.00	PHYSICIAN OFFICE	194.01	0	39,068	0		1.00
2.00	RHC - PAXTON CLINIC	88.00	0	204,053	0		2.00
3.00	RHC III - FORREST CLINIC	88.02	0	70,397	0		3.00
4.00	RHC IV - HOOPESTON	88.03	0	48,532	0		4.00
5.00	RHC V - FARMER CITY	88.04	0	50,279	0		5.00
6.00	RHC VI - GIBSON CITY	88.05	0	29,274	0		6.00
7.00	ORTHO CLINIC	90.02	0	128,340	0		7.00
8.00	PHYSICIAN CLINICS	194.02	0	33,461	0		8.00
9.00	MAHOMET SPECIALTY CLINIC	194.05	0	195	0		9.00
10.00	GAH CARDIOLOGY	194.09	0	31,889	0		10.00
11.00	FAMILY HEALTHCARE OF POTOMAC	194.12	0	15,762	0		11.00
12.00	PSYCH CLINIC	194.04	0	19,588	0		12.00
	TOTALS		0	670,838			
	E - ADM LONG TERM CARE FEES						
1.00	OTHER LONG TERM CARE	46.00	0	94,991	0		1.00
	TOTALS		0	94,991			
	F - SNF DIRECT CARE COST						
1.00	OTHER LONG TERM CARE	46.00	73,453	8,022	0		1.00
	TOTALS		73,453	8,022			
	G - BOND AMORT COST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,045	14		1.00
	TOTALS		0	2,045			
	H - MME DEPRE						
1.00	RHC - PAXTON CLINIC	88.00	0	702	9		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	5,216	0		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	681,510	11		3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	423,335	11		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
	TOTALS		0	1,110,763			
	I - CAPITAL INSURANCE EXP						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	126,607	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	126,607			
	J - NUCLEAR MED TECH SALARY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	105,111	0	0		1.00
	TOTALS		105,111	0			
	K - AMBULANCE BILLING & UTILITIES COST						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	38,302	0	0		1.00
2.00	AMBULANCE SERVICES	95.00	0	9,779	0		2.00
	TOTALS		38,302	9,779			

RECLASSIFICATIONS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/24/2015 4:07 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - PHYSICIAN COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	25,425	0		1.00
	TOTALS		0	25,425			
	M - DIETARY EDUCATION						
1.00	DIETARY	10.00	0	98,981	0		1.00
	TOTALS		0	98,981			
	N - RHC SALARIES						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	O - RHC PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	586,147	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	TOTALS		0	586,147			
500.00	Grand Total: Decreases		1,048,969	3,579,907			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/24/2015 4:07 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	344,036	200,796	0	200,796	0	1.00
2.00	Land Improvements	1,345,341	0	0	0	0	2.00
3.00	Buildings and Fixtures	24,493,185	1,756,970	0	1,756,970	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	18,352,407	0	0	0	-580,344	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,534,969	1,957,766	0	1,957,766	-580,344	8.00
9.00	Reconciling Items	-6,036,854	-1,338,204	0	-1,338,204	0	9.00
10.00	Total (line 8 minus line 9)	50,571,823	3,295,970	0	3,295,970	-580,344	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	544,832	0	1.00
2.00	Land Improvements	1,345,341	0	2.00
3.00	Buildings and Fixtures	26,250,155	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	18,932,751	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,073,079	0	8.00
9.00	Reconciling Items	-7,375,058	0	9.00
10.00	Total (line 8 minus line 9)	54,448,137	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/24/2015 4:07 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,252,090	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,252,090	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,252,090	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,252,090	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 2/24/2015 4:07 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	28,140,328	0	28,140,328	0.597801	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,932,751	0	18,932,751	0.402199	0	2.00
3.00	Total (sum of lines 1-2)	47,073,079	0	47,073,079	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,210,487	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	668,795	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,879,282	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	CAP REL COSTS-BLDG & FIXT	-815,626	105,861	0	-2,045	1,498,677	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,591	20,746	0	2,045	740,177	2.00
3.00	Total (sum of lines 1-2)	-767,035	126,607	0	0	2,238,854	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/24/2015 4:07 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,055,723			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	-18,632	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	A&G MISC REV	B	-41,974	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/24/2015 4:07 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	DR BARK DIRECTOR FEES	B	-21,994	RHC - PAXTON CLINIC	88.00	0	33.01
33.02	COMMUNITY ED INCOME -OT/OP REV	B	-1,000	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.02
33.03	NH DIRECTOR FEES- FARMERS CITY	B	-6,000	RHC V - FARMER CITY	88.04	0	33.03
33.04	SCHOOL NURSING INCOME	B	-102,000	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.04
33.05	LIFELINE INCOME	B	-8,134	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.05
33.06	CAFE MISC REV	B	-79,342	CAFETERIA	11.00	0	33.06
33.07	LAUNDRY MISC REV	B	-67	LAUNDRY & LINEN SERVICE	8.00	0	33.07
33.08	MED RECORDS MISC REV	B	-231	MEDICAL RECORDS & LIBRARY	16.00	0	33.08
33.09	RENTAL INC - OPC	B	-41,603	CAP REL COSTS-BLDG & FIXT	1.00	9	33.09
33.10	INVEST INCOME - B&F	B	-48,945	CAP REL COSTS-BLDG & FIXT	1.00	11	33.10
33.11	INVEST INCOME - MME	B	-8,223	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.11
33.12	INVEST INCOME - PAXTON	B	-14,771	RHC - PAXTON CLINIC	88.00	0	33.12
33.13	INVEST INCOME - ONARGA	B	-1,640	RHC II -ONARGA CLINIC	88.01	0	33.13
33.14	INVEST INCOME - FORREST	B	-6,762	RHC III - FORREST CLINIC	88.02	0	33.14
33.15	INVEST INCOME - AMBULANCE	B	-1,899	AMBULANCE SERVICES	95.00	0	33.15
33.16	INVEST INCOME - FARMER CITY	B	-4,195	RHC V - FARMER CITY	88.04	0	33.16
33.17	INTERNALLY ALLOCATED RENT EXP - RHC	A	-70,800	RHC - PAXTON CLINIC	88.00	0	33.17
33.18	INTERNALLY ALLOCATED RENT EXP - RHC	A	-1,700	RHC II -ONARGA CLINIC	88.01	0	33.18
33.19	INTERNALLY ALLOCATED RENT EXP - RHC	A	-33,900	RHC III - FORREST CLINIC	88.02	0	33.19
33.20	INTERNALLY ALLOCATED RENT EXP - RHC	A	-15,600	RHC IV - HOOPESTON	88.03	0	33.20
33.21	INTERNALLY ALLOCATED RENT EXP - RHC	A	-20,628	RHC V - FARMER CITY	88.04	0	33.21
33.22	INTERNALLY ALLOCATED RENT EXP - RHC	A	-19,200	RHC VI - GIBSON CITY	88.05	0	33.22
33.23	INTERNALLY ALLOCATED RENT EXP - ORTH	A	-35,680	ORTHO CLINIC	90.02	0	33.23
33.24	HOUSE RENT	A	-5,990	OPERATION OF PLANT	7.00	0	33.24
33.25	HOUSE RENT	A	-4,000	ANESTHESIOLOGY	53.00	0	33.25
33.26	ONARGA DRS HOSP VISIT	A	-463	RHC II -ONARGA CLINIC	88.01	0	33.26
33.27			0		0.00	0	33.27
33.28			0		0.00	0	33.28
33.29			0		0.00	0	33.29
33.30			0		0.00	0	33.30
33.31			0		0.00	0	33.31
33.32			0		0.00	0	33.32
33.33			0		0.00	0	33.33
34.00	INTERNALLY ALLOCATED RENT EXP - PO	A	-1,200	PHYSICIAN OFFICE	194.01	0	34.00
35.00	INTERNALLY ALLOCATED RENT EXP - PC	A	-4,600	PHYSICIAN CLINICS	194.02	0	35.00
36.00	INTERNALLY ALLOCATED RENT EXP - CLIN	A	-2,500	PAIN CLINIC	194.07	0	36.00
37.00	HOUSE RENT	A	-500	MAHOMET SPECIALTY CLINIC	194.05	0	37.00
38.01	CRNA NONSALARY EXPEN	A	-405,070	ANESTHESIOLOGY	53.00	0	38.01
40.00	LOBBYING DUES	A	-18,880	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	40.00
41.00	STATE PROVIDER TAX EXP	A	-258,120	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
42.00	CRNA SALARIES	A	-1,007,764	ANESTHESIOLOGY	53.00	0	42.00
43.00	CRNA BENEFITS	A	-191,364	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.00
44.00	PHYSICIAN RECRUITMENT	A	-3,424	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	44.00
45.00	PUBLIC RELATIONS OFFSET	A	-502,279	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	45.00
45.01	GIBSON PHO EXP	A	-528,996	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	45.01
45.02	ONARGA LAB SRVCS COST	A	-192	RHC II -ONARGA CLINIC	88.01	0	45.02
45.03	PAXTON LAB SRVC COST	A	-32,671	RHC - PAXTON CLINIC	88.00	0	45.03
45.04	FORREST LAB SERVICE COST	A	-8,628	RHC III - FORREST CLINIC	88.02	0	45.04
45.05	MISC DONATIONS (COMM ED)	A	-193,654	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	45.05
45.07	PT B PHYSICIAN BENEFITS	A	-125,198	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.07
45.08	PAXTON DRS HOSP VISIT	A	-86,525	RHC - PAXTON CLINIC	88.00	0	45.08

ADJUSTMENTS TO EXPENSES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/24/2015 4:07 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	
45.10	FORREST DRS HOSP VISIT	A	-32,525	RHC III - FORREST CLINIC	88.02	0	45.10
45.11	HOOPSTON DRS HOSP VISIT	A	-29,991	RHC IV - HOOPESTON	88.03	0	45.11
45.13	FARMER CITY DRS HOSP VISIT	A	-10,269	RHC V - FARMER CITY	88.04	0	45.13
45.14	GIBSON CITY DRS HOSP VISIT	A	-65,936	RHC VI - GIBSON CITY	88.05	0	45.14
45.15	OP STATE PROVIDER TAX EXP	A	-269,429	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,450,811				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/24/2015 4:07 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	44.00	SKILLED NURSING FACILITY	19,200	0	19,200	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	9,679	9,679	0	0	0	2.00
3.00	73.01	CARDIAC REHAB	7,350	0	7,350	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	661,700	661,700	0	0	0	4.00
5.00	91.00	EMERGENCY	1,785,394	1,283,704	501,690	0	0	5.00
6.00	60.00	LABORATORY	3,300	3,300	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	647,391	17,391	630,000	0	0	7.00
8.00	50.00	OPERATING ROOM	11,400	11,400	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	44,032	44,032	0	0	0	9.00
10.00	73.03	SLEEP LAB	101,200	0	101,200	0	0	10.00
11.00	90.01	GERI PSYCH CLINIC	34,050	34,050	0	0	0	11.00
12.00	90.02	ORTHO CLINIC	383,658	383,658	0	0	0	12.00
13.00	90.02	ORTHO CLINIC	1,119,038	1,119,038	0	0	0	13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	82,701	82,701	0	0	0	14.00
15.00	53.00	ANESTHESIOLOGY	405,070	405,070	0	0	0	15.00
200.00			5,315,163	4,055,723	1,259,440		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	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	73.01	CARDIAC REHAB	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	9.00
10.00	73.03	SLEEP LAB	0	0	0	0	0	10.00
11.00	90.01	GERI PSYCH CLINIC	0	0	0	0	0	11.00
12.00	90.02	ORTHO CLINIC	0	0	0	0	0	12.00
13.00	90.02	ORTHO CLINIC	0	0	0	0	0	13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	14.00
15.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	15.00
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	44.00	SKILLED NURSING FACILITY	0	0	0	0		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	9,679		2.00
3.00	73.01	CARDIAC REHAB	0	0	0	0		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	661,700		4.00
5.00	91.00	EMERGENCY	0	0	0	1,283,704		5.00
6.00	60.00	LABORATORY	0	0	0	3,300		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	17,391		7.00
8.00	50.00	OPERATING ROOM	0	0	0	11,400		8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	44,032		9.00
10.00	73.03	SLEEP LAB	0	0	0	0		10.00
11.00	90.01	GERI PSYCH CLINIC	0	0	0	34,050		11.00
12.00	90.02	ORTHO CLINIC	0	0	0	383,658		12.00
13.00	90.02	ORTHO CLINIC	0	0	0	1,119,038		13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	82,701		14.00
15.00	53.00	ANESTHESIOLOGY	0	0	0	405,070		15.00
200.00			0	0	0	4,055,723		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,498,677	1,498,677				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	740,177		740,177			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,314,507	7,477	0	8,321,984		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,767,985	6,054	0	383,558	2,157,597	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	6,942,399	166,075	115,094	1,129,604	8,353,172	5.02
7.00	00700	OPERATION OF PLANT	2,033,726	416,562	2,144	220,178	2,672,610	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	168,431	19,897	6,695	41,205	236,228	8.00
9.00	00900	HOUSEKEEPING	370,549	6,343	0	103,374	480,266	9.00
10.00	01000	DIETARY	232,940	29,064	7,733	67,478	337,215	10.00
11.00	01100	CAFETERIA	356,906	9,225	0	88,687	454,818	11.00
13.00	01300	NURSING ADMINISTRATION	448,769	3,449	0	99,502	551,720	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,285	8,149	0	0	79,434	14.00
15.00	01500	PHARMACY	500,579	15,337	0	133,657	649,573	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	372,574	11,934	81	109,755	494,344	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,571,988	153,296	39,280	783,214	3,547,778	30.00
31.00	03100	INTENSIVE CARE UNIT	589,315	11,228	0	200,766	801,309	31.00
43.00	04300	NURSERY	485,270	3,692	0	150,674	639,636	43.00
44.00	04400	SKILLED NURSING FACILITY	81,475	13,253	0	25,433	120,161	44.00
46.00	04600	OTHER LONG TERM CARE	1,567,140	141,594	9,029	489,186	2,206,949	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,570,501	70,965	135,035	593,719	3,370,220	50.00
51.00	05100	RECOVERY ROOM	352,262	14,619	332	107,792	475,005	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	156,999	12,501	0	48,747	218,247	52.00
53.00	05300	ANESTHESIOLOGY	249,523	1,134	14,368	0	265,025	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,673,583	83,651	217,271	329,090	3,303,595	54.00
56.00	05600	RADIOISOTOPE	223,720	7,628	0	36,394	267,742	56.00
60.00	06000	LABORATORY	1,639,817	21,726	29,034	267,189	1,957,766	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	146,625	1,783	0	0	148,408	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	492,942	5,220	9,518	145,254	652,934	65.00
66.00	06600	PHYSICAL THERAPY	1,669,056	123,260	14,904	505,260	2,312,480	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,192	2,604	0	52,717	215,513	67.00
68.00	06800	SPEECH PATHOLOGY	58,666	2,604	0	18	61,288	68.00
69.00	06900	ELECTROCARDIOLOGY	3,349	0	2,875	0	6,224	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	841,751	0	0	0	841,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,039,115	0	0	0	3,039,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,249,331	0	0	0	1,249,331	73.00
73.01	07301	CARDIAC REHAB	96,145	11,702	4,684	29,755	142,286	73.01
73.02	07302	WOUND CARE	168,150	7,744	0	54,236	230,130	73.02
73.03	07303	SLEEP LAB	191,341	0	93	28,313	219,747	73.03
73.04	03950	DIETARY EDUCATION	98,981	0	0	0	98,981	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	3,548,022	0	9,995	268,226	3,826,243	88.00
88.01	08801	RHC II -ONARGA CLINIC	883,502	0	0	76,502	960,004	88.01
88.02	08802	RHC III - FORREST CLINIC	1,489,672	0	3,180	115,937	1,608,789	88.02
88.03	08803	RHC IV - HOOPESTON	823,241	0	10,767	72,252	906,260	88.03
88.04	08804	RHC V - FARMER CITY	594,885	0	3,273	39,336	637,494	88.04
88.05	08805	RHC VI - GIBSON CITY	728,705	0	0	63,170	791,875	88.05
90.00	09000	CLINIC	301,519	27,444	0	89,880	418,843	90.00
90.01	09001	GERI PSYCH CLINIC	357,328	0	0	64,655	421,983	90.01
90.02	09002	ORTHO CLINIC	452,755	0	0	56,757	509,512	90.02
91.00	09100	EMERGENCY	1,826,974	77,539	32,355	407,769	2,344,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,148,676	0	50,002	615,611	2,814,289	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,352,020	1,494,753	717,742	8,094,850	58,098,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,924	0	0	3,924	190.00
192.01	19201	GAH - MSO	327,475	0	0	62,240	389,715	192.01
192.02	19202	GAH FOUNDATION	182,443	0	0	3,689	186,132	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	3,650	0	0	0	3,650	194.00
194.01	07951	PHYSICIAN OFFICE	705,329	0	22,435	37,129	764,893	194.01
194.02	07952	PHYSICIAN CLINICS	948,535	0	0	1,375	949,910	194.02
194.03	07953	WELLNESS CENTER	173,306	0	0	33,299	206,605	194.03
194.04	07954	PSYCH CLINIC	220,238	0	0	4,234	224,472	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	134,601	0	0	10,625	145,226	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.06	07956	LASER CLINIC	6,894	0	0	100	6,994	194.06
194.07	07957	PAIN CLINIC	75,548	0	0	71	75,619	194.07
194.08	07958	340B PHARMACY	206,795	0	0	0	206,795	194.08
194.09	07959	GAH CARDIOLOGY	410,142	0	0	2,777	412,919	194.09
194.10	07960	WIC	108,868	0	0	34,805	143,673	194.10
194.11	07961	PULMONARY CLINIC	303	0	0	0	303	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	338,124	0	0	36,790	374,914	194.12
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)	62,194,271	1,498,677	740,177	8,321,984	62,194,271	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	2,157,597					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	412,776	8,765,948	8,765,948			5.02
7.00	00700	OPERATION OF PLANT	132,064	2,804,674	460,160	3,264,834		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,673	247,901	40,673	33,181	321,755	8.00
9.00	00900	HOUSEKEEPING	23,732	503,998	82,690	10,578	29,305	9.00
10.00	01000	DIETARY	16,663	353,878	58,060	48,469	3,611	10.00
11.00	01100	CAFETERIA	22,474	477,292	78,309	15,384	6,356	11.00
13.00	01300	NURSING ADMINISTRATION	27,263	578,983	94,993	5,752	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,925	83,359	13,677	13,589	0	14.00
15.00	01500	PHARMACY	32,098	681,671	111,841	25,576	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,428	518,772	85,114	19,901	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	175,310	3,723,088	610,843	255,645	68,595	30.00
31.00	03100	INTENSIVE CARE UNIT	39,596	840,905	137,966	18,724	0	31.00
43.00	04300	NURSERY	31,607	671,243	110,130	6,158	2,689	43.00
44.00	04400	SKILLED NURSING FACILITY	0	120,161	19,715	22,102	16,506	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,206,949	362,092	236,130	93,645	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	166,536	3,536,756	580,272	118,345	34,675	50.00
51.00	05100	RECOVERY ROOM	23,472	498,477	81,785	24,379	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,784	229,031	37,577	20,847	11,089	52.00
53.00	05300	ANESTHESIOLOGY	13,096	278,121	45,631	39,995	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,244	3,466,839	568,801	139,500	12,604	54.00
56.00	05600	RADIOISOTOPE	13,230	280,972	46,099	12,720	0	56.00
60.00	06000	LABORATORY	96,741	2,054,507	337,081	36,231	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,333	155,741	25,552	2,973	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	32,264	685,198	112,420	8,706	0	65.00
66.00	06600	PHYSICAL THERAPY	114,269	2,426,749	398,154	525,302	15,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,649	226,162	37,106	4,343	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,028	64,316	10,552	4,343	0	68.00
69.00	06900	ELECTROCARDIOLOGY	308	6,532	1,072	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,594	883,345	144,930	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,175	3,189,290	523,264	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,734	1,311,065	215,105	0	0	73.00
73.01	07301	CARDIAC REHAB	7,031	149,317	24,498	19,515	0	73.01
73.02	07302	WOUND CARE	11,372	241,502	39,623	12,913	0	73.02
73.03	07303	SLEEP LAB	10,859	230,606	37,835	0	0	73.03
73.04	03950	DIETARY EDUCATION	4,891	103,872	17,042	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	3,826,243	627,788	374,761	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	960,004	157,507	96,513	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,608,789	263,952	90,877	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	906,260	148,689	38,605	0	88.03
88.04	08804	RHC V - FARMER CITY	0	637,494	104,593	41,694	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	791,875	129,922	77,828	0	88.05
90.00	09000	CLINIC	20,697	439,540	72,115	45,767	0	90.00
90.01	09001	GERI PSYCH CLINIC	20,852	442,835	72,655	77,828	0	90.01
90.02	09002	ORTHO CLINIC	25,177	534,689	87,726	44,300	0	90.02
91.00	09100	EMERGENCY	115,858	2,460,495	403,691	129,309	26,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,814,289	461,738	194,455	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,078,803	58,019,733	8,081,038	2,893,238	321,755	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,924	644	6,544	0	190.00
192.01	19201	GAH - MSO	0	389,715	63,940	0	0	192.01
192.02	19202	GAH FOUNDATION	0	186,132	30,538	0	0	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	180	3,830	628	37,216	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	764,893	125,495	54,047	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	949,910	155,851	29,996	0	194.02
194.03	07953	WELLNESS CENTER	0	206,605	33,897	135,119	0	194.03
194.04	07954	PSYCH CLINIC	11,092	235,564	38,649	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	7,176	152,402	25,004	41,115	0	194.05
194.06	07956	LASER CLINIC	346	7,340	1,204	0	0	194.06
194.07	07957	PAIN CLINIC	3,737	79,356	13,020	0	0	194.07
194.08	07958	340B PHARMACY	10,219	217,014	35,605	0	0	194.08
194.09	07959	GAH CARDIOLOGY	20,404	433,323	71,095	0	0	194.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
194.10	07960	WIC	7,099	150,772	24,737	0	0	194.10
194.11	07961	PULMONARY CLINIC	15	318	52	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	18,526	393,440	64,551	67,559	0	194.12
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,157,597	62,194,271	8,765,948	3,264,834	321,755	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/24/2015 4:07 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	626,571					9.00
10.00	01000	DIETARY	13,594	477,612				10.00
11.00	01100	CAFETERIA	4,315	0	581,656			11.00
13.00	01300	NURSING ADMINISTRATION	1,613	0	7,124	688,465		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,811	0	0	0	114,436	14.00
15.00	01500	PHARMACY	7,173	0	3,590	0	102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,581	0	14,654	0	46	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,698	107,921	78,267	185,722	3,319	30.00
31.00	03100	INTENSIVE CARE UNIT	5,251	1,061	12,119	28,740	5	31.00
43.00	04300	NURSERY	1,727	0	11,694	27,741	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,199	18,218	3,145	7,454	0	44.00
46.00	04600	OTHER LONG TERM CARE	66,225	350,412	60,412	143,378	795	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,191	0	51,919	123,218	9,830	50.00
51.00	05100	RECOVERY ROOM	6,837	0	12,841	30,484	586	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,847	0	3,775	8,976	0	52.00
53.00	05300	ANESTHESIOLOGY	11,217	0	6,735	0	884	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,124	0	49,458	0	399	54.00
56.00	05600	RADIOISOTOPE	3,568	0	8,604	0	29	56.00
60.00	06000	LABORATORY	10,161	0	37,357	0	983	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	834	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,442	0	14,876	35,299	58	65.00
66.00	06600	PHYSICAL THERAPY	147,329	0	46,387	0	97	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,218	0	3,460	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,218	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	20,273	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	73,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	5,473	0	2,627	6,255	14	73.01
73.02	07302	WOUND CARE	3,622	0	3,016	7,146	133	73.02
73.03	07303	SLEEP LAB	0	0	3,016	7,142	6	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	0	0	385	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	0	141	88.01
88.02	08802	RHC III - FORREST CLINIC	7,709	0	0	0	228	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0	0	49	88.03
88.04	08804	RHC V - FARMER CITY	0	0	0	0	51	88.04
88.05	08805	RHC VI - GIBSON CITY	21,828	0	0	0	220	88.05
90.00	09000	CLINIC	12,836	0	9,048	21,476	260	90.00
90.01	09001	GERI PSYCH CLINIC	21,828	0	0	0	16	90.01
90.02	09002	ORTHO CLINIC	12,424	0	29,586	0	114	90.02
91.00	09100	EMERGENCY	36,266	0	23,351	55,434	1,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	17,475	0	84,595	0	251	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	589,634	477,612	581,656	688,465	114,132	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,835	0	0	0	0	190.00
192.01	19201	GAH - MSO	0	0	0	0	23	192.01
192.02	19202	GAH FOUNDATION	0	0	0	0	0	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	15,158	0	0	0	25	194.01
194.02	07952	PHYSICIAN CLINICS	8,413	0	0	0	38	194.02
194.03	07953	WELLNESS CENTER	0	0	0	0	56	194.03
194.04	07954	PSYCH CLINIC	0	0	0	0	7	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	11,531	0	0	0	66	194.05
194.06	07956	LASER CLINIC	0	0	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	0	0	194.07
194.08	07958	340B PHARMACY	0	0	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	0	0	0	0	0	194.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
194.10	07960	WIC	0	0	0	0	7	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	0	0	0	82	194.12
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)	626,571	477,612	581,656	688,465	114,436	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	829,953					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	644,068				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,015	103,448	5,210,561	-26,987	5,183,574	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,958	1,046,729	0	1,046,729	31.00
43.00	04300	NURSERY	0	1,037	832,419	0	832,419	43.00
44.00	04400	SKILLED NURSING FACILITY	0	11,441	224,941	0	224,941	44.00
46.00	04600	OTHER LONG TERM CARE	173	0	3,520,211	0	3,520,211	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,203	115,465	4,609,874	0	4,609,874	50.00
51.00	05100	RECOVERY ROOM	0	0	655,389	0	655,389	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	317,142	0	317,142	52.00
53.00	05300	ANESTHESIOLOGY	9,295	0	391,878	0	391,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,777	156,888	4,436,390	0	4,436,390	54.00
56.00	05600	RADIOISOTOPE	44	0	352,036	0	352,036	56.00
60.00	06000	LABORATORY	34	45,767	2,522,121	0	2,522,121	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	185,100	0	185,100	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	26,987	26,987	64.00
65.00	06500	RESPIRATORY THERAPY	71	13,169	872,239	0	872,239	65.00
66.00	06600	PHYSICAL THERAPY	322	7,141	3,567,477	0	3,567,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	272,289	0	272,289	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	80,429	0	80,429	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,606	0	7,606	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,048,548	0	1,048,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,785,749	0	3,785,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	721,162	0	2,247,332	0	2,247,332	73.00
73.01	07301	CARDIAC REHAB	0	3,839	211,538	0	211,538	73.01
73.02	07302	WOUND CARE	46	9,790	317,791	0	317,791	73.02
73.03	07303	SLEEP LAB	122	8,485	287,212	0	287,212	73.03
73.04	03950	DIETARY EDUCATION	0	0	120,914	0	120,914	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	27,752	0	4,856,929	0	4,856,929	88.00
88.01	08801	RHC II -ONARGA CLINIC	4,329	0	1,218,494	0	1,218,494	88.01
88.02	08802	RHC III - FORREST CLINIC	6,585	0	1,978,140	0	1,978,140	88.02
88.03	08803	RHC IV - HOOPESTON	2,877	0	1,096,480	0	1,096,480	88.03
88.04	08804	RHC V - FARMER CITY	2,216	0	786,048	0	786,048	88.04
88.05	08805	RHC VI - GIBSON CITY	5,690	0	1,027,363	0	1,027,363	88.05
90.00	09000	CLINIC	324	10,132	611,498	0	611,498	90.00
90.01	09001	GERI PSYCH CLINIC	0	5,260	620,422	0	620,422	90.01
90.02	09002	ORTHO CLINIC	21,907	21,615	752,361	0	752,361	90.02
91.00	09100	EMERGENCY	496	128,633	3,266,020	0	3,266,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,476	0	3,576,279	0	3,576,279	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	817,916	644,068	56,913,949	0	56,913,949	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12,947	0	12,947	190.00
192.01	19201	GAH - MSO	0	0	453,678	0	453,678	192.01
192.02	19202	GAH FOUNDATION	0	0	216,670	0	216,670	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	41,674	0	41,674	194.00
194.01	07951	PHYSICIAN OFFICE	56	0	959,674	0	959,674	194.01
194.02	07952	PHYSICIAN CLINICS	2,958	0	1,147,166	0	1,147,166	194.02
194.03	07953	WELLNESS CENTER	0	0	375,677	0	375,677	194.03
194.04	07954	PSYCH CLINIC	0	0	274,220	0	274,220	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	368	0	230,486	0	230,486	194.05
194.06	07956	LASER CLINIC	0	0	8,544	0	8,544	194.06
194.07	07957	PAIN CLINIC	0	0	92,376	0	92,376	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
194.08	07958	340B PHARMACY	0	0	252,619	0	252,619	194.08
194.09	07959	GAH CARDIOLOGY	131	0	504,549	0	504,549	194.09
194.10	07960	WIC	0	0	175,516	0	175,516	194.10
194.11	07961	PULMONARY CLINIC	0	0	370	0	370	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	8,524	0	534,156	0	534,156	194.12
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)	829,953	644,068	62,194,271	0	62,194,271	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,477	0	7,477	7,477	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	6,054	0	6,054	345	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	0	166,075	115,094	281,169	1,017	5.02
7.00	00700	OPERATION OF PLANT	0	416,562	2,144	418,706	198	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,897	6,695	26,592	37	8.00
9.00	00900	HOUSEKEEPING	0	6,343	0	6,343	93	9.00
10.00	01000	DIETARY	0	29,064	7,733	36,797	61	10.00
11.00	01100	CAFETERIA	0	9,225	0	9,225	80	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,449	0	3,449	89	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,149	0	8,149	0	14.00
15.00	01500	PHARMACY	0	15,337	0	15,337	120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,934	81	12,015	99	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	153,296	39,280	192,576	703	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,228	0	11,228	180	31.00
43.00	04300	NURSERY	0	3,692	0	3,692	135	43.00
44.00	04400	SKILLED NURSING FACILITY	0	13,253	0	13,253	23	44.00
46.00	04600	OTHER LONG TERM CARE	0	141,594	9,029	150,623	439	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	70,965	135,035	206,000	533	50.00
51.00	05100	RECOVERY ROOM	0	14,619	332	14,951	97	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,501	0	12,501	44	52.00
53.00	05300	ANESTHESIOLOGY	0	1,134	14,368	15,502	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,651	217,271	300,922	296	54.00
56.00	05600	RADIOISOTOPE	0	7,628	0	7,628	33	56.00
60.00	06000	LABORATORY	0	21,726	29,034	50,760	240	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,783	0	1,783	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,220	9,518	14,738	130	65.00
66.00	06600	PHYSICAL THERAPY	0	123,260	14,904	138,164	454	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,604	0	2,604	47	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,604	0	2,604	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,875	2,875	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	11,702	4,684	16,386	27	73.01
73.02	07302	WOUND CARE	0	7,744	0	7,744	49	73.02
73.03	07303	SLEEP LAB	0	0	93	93	25	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	9,995	9,995	241	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	0	69	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	3,180	3,180	104	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	10,767	10,767	65	88.03
88.04	08804	RHC V - FARMER CITY	0	0	3,273	3,273	35	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0	0	57	88.05
90.00	09000	CLINIC	0	27,444	0	27,444	81	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	58	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	51	90.02
91.00	09100	EMERGENCY	0	77,539	32,355	109,894	366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	50,002	50,002	553	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,494,753	717,742	2,212,495	7,274	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,924	0	3,924	0	190.00
192.01	19201	GAH - MSO	0	0	0	0	56	192.01
192.02	19202	GAH FOUNDATION	0	0	0	0	3	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	0	22,435	22,435	33	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	0	1	194.02
194.03	07953	WELLNESS CENTER	0	0	0	0	30	194.03
194.04	07954	PSYCH CLINIC	0	0	0	0	4	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	0	0	0	10	194.05
194.06	07956	LASER CLINIC	0	0	0	0	0	194.06

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		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.07	07957	PAIN CLINIC	0	0	0	0	0	194.07
194.08	07958	340B PHARMACY	0	0	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	0	0	0	0	2	194.09
194.10	07960	WIC	0	0	0	0	31	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	0	0	0	33	194.12
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,498,677	740,177	2,238,854	7,477	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	6,399					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,204	283,390				5.02
7.00	00700	OPERATION OF PLANT	393	14,876	434,173			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35	1,315	4,413	32,392		8.00
9.00	00900	HOUSEKEEPING	71	2,673	1,407	2,950	13,537	9.00
10.00	01000	DIETARY	50	1,877	6,446	364	294	10.00
11.00	01100	CAFETERIA	67	2,532	2,046	640	93	11.00
13.00	01300	NURSING ADMINISTRATION	81	3,071	765	0	35	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12	442	1,807	0	82	14.00
15.00	01500	PHARMACY	95	3,616	3,401	0	155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	73	2,752	2,647	0	121	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	522	19,747	33,997	6,906	1,549	30.00
31.00	03100	INTENSIVE CARE UNIT	118	4,460	2,490	0	113	31.00
43.00	04300	NURSERY	94	3,560	819	271	37	43.00
44.00	04400	SKILLED NURSING FACILITY	0	637	2,939	1,662	134	44.00
46.00	04600	OTHER LONG TERM CARE	0	11,706	31,402	9,427	1,431	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	495	18,759	15,738	3,491	717	50.00
51.00	05100	RECOVERY ROOM	70	2,644	3,242	0	148	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32	1,215	2,772	1,116	126	52.00
53.00	05300	ANESTHESIOLOGY	39	1,475	5,319	0	242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486	18,388	18,551	1,269	845	54.00
56.00	05600	RADIOISOTOPE	39	1,490	1,692	0	77	56.00
60.00	06000	LABORATORY	288	10,897	4,818	0	220	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	22	826	395	0	18	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	96	3,634	1,158	0	53	65.00
66.00	06600	PHYSICAL THERAPY	340	12,871	69,855	1,610	3,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	32	1,200	578	0	26	67.00
68.00	06800	SPEECH PATHOLOGY	9	341	578	0	26	68.00
69.00	06900	ELECTROCARDIOLOGY	1	35	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124	4,685	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	447	16,916	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184	6,954	0	0	0	73.00
73.01	07301	CARDIAC REHAB	21	792	2,595	0	118	73.01
73.02	07302	WOUND CARE	34	1,281	1,717	0	78	73.02
73.03	07303	SLEEP LAB	32	1,223	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	15	551	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	20,302	49,838	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	5,092	12,835	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	8,533	12,085	0	167	88.02
88.03	08803	RHC IV - HOOPESTON	0	4,807	5,134	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	3,381	5,545	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	4,200	10,350	0	472	88.05
90.00	09000	CLINIC	62	2,331	6,086	0	277	90.00
90.01	09001	GERI PSYCH CLINIC	62	2,349	10,350	0	472	90.01
90.02	09002	ORTHO CLINIC	75	2,836	5,891	0	268	90.02
91.00	09100	EMERGENCY	345	13,050	17,196	2,686	784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	14,927	25,860	0	378	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,165	261,249	384,757	32,392	12,739	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21	870	0	40	190.00
192.01	19201	GAH - MSO	0	2,067	0	0	0	192.01
192.02	19202	GAH FOUNDATION	0	987	0	0	0	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	1	20	4,949	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	4,057	7,187	0	327	194.01
194.02	07952	PHYSICIAN CLINICS	0	5,038	3,989	0	182	194.02
194.03	07953	WELLNESS CENTER	0	1,096	17,969	0	0	194.03
194.04	07954	PSYCH CLINIC	33	1,249	0	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	21	808	5,468	0	249	194.05
194.06	07956	LASER CLINIC	1	39	0	0	0	194.06
194.07	07957	PAIN CLINIC	11	421	0	0	0	194.07
194.08	07958	340B PHARMACY	30	1,151	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	61	2,298	0	0	0	194.09

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		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
194.10	07960	WIC	21	800	0	0	0	194.10
194.11	07961	PULMONARY CLINIC	0	2	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	55	2,087	8,984	0	0	194.12
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)	6,399	283,390	434,173	32,392	13,537	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	45,889					10.00
11.00	01100	CAFETERIA	0	14,683				11.00
13.00	01300	NURSING ADMINISTRATION	0	180	7,670			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	10,492		14.00
15.00	01500	PHARMACY	0	91	0	9	22,824	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	370	0	4	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,369	1,976	2,068	304	55	30.00
31.00	03100	INTENSIVE CARE UNIT	102	306	320	0	0	31.00
43.00	04300	NURSERY	0	295	309	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,750	79	83	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	33,668	1,525	1,597	73	5	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,311	1,373	901	171	50.00
51.00	05100	RECOVERY ROOM	0	324	340	54	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	95	100	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	170	0	81	256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,248	0	37	76	54.00
56.00	05600	RADIOISOTOPE	0	217	0	3	1	56.00
60.00	06000	LABORATORY	0	943	0	90	1	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	376	393	5	2	65.00
66.00	06600	PHYSICAL THERAPY	0	1,171	0	9	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	87	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,859	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,712	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	19,833	73.00
73.01	07301	CARDIAC REHAB	0	66	70	1	0	73.01
73.02	07302	WOUND CARE	0	76	80	12	1	73.02
73.03	07303	SLEEP LAB	0	76	80	1	3	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	0	35	763	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	13	119	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0	21	181	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0	5	79	88.03
88.04	08804	RHC V - FARMER CITY	0	0	0	5	61	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0	20	156	88.05
90.00	09000	CLINIC	0	228	239	24	9	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	1	0	90.01
90.02	09002	ORTHO CLINIC	0	747	0	10	602	90.02
91.00	09100	EMERGENCY	0	589	618	152	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,137	0	23	96	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,889	14,683	7,670	10,464	22,493	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.01	19201	GAH - MSO	0	0	0	2	0	192.01
192.02	19202	GAH FOUNDATION	0	0	0	0	0	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	0	0	2	2	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	3	81	194.02
194.03	07953	WELLNESS CENTER	0	0	0	5	0	194.03
194.04	07954	PSYCH CLINIC	0	0	0	1	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	0	0	6	10	194.05
194.06	07956	LASER CLINIC	0	0	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	0	0	194.07
194.08	07958	340B PHARMACY	0	0	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	0	0	0	0	4	194.09

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
194.10	07960	WIC	0	0	0	1	0	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	0	0	8	234	194.12
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)	45,889	14,683	7,670	10,492	22,824	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,081					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,904	273,676	0	273,676		30.00
31.00	03100	INTENSIVE CARE UNIT	55	19,372	0	19,372		31.00
43.00	04300	NURSERY	29	9,241	0	9,241		43.00
44.00	04400	SKILLED NURSING FACILITY	321	20,881	0	20,881		44.00
46.00	04600	OTHER LONG TERM CARE	0	241,896	0	241,896		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,241	252,730	0	252,730		50.00
51.00	05100	RECOVERY ROOM	0	21,870	0	21,870		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,001	0	18,001		52.00
53.00	05300	ANESTHESIOLOGY	0	23,084	0	23,084		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,405	346,523	0	346,523		54.00
56.00	05600	RADIOISOTOPE	0	11,180	0	11,180		56.00
60.00	06000	LABORATORY	1,285	69,542	0	69,542		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,044	0	3,044		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	370	20,955	0	20,955		65.00
66.00	06600	PHYSICAL THERAPY	200	227,866	0	227,866		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,574	0	4,574		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,558	0	3,558		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,911	0	2,911		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,668	0	6,668		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,075	0	24,075		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,971	0	26,971		73.00
73.01	07301	CARDIAC REHAB	108	20,184	0	20,184		73.01
73.02	07302	WOUND CARE	275	11,347	0	11,347		73.02
73.03	07303	SLEEP LAB	238	1,771	0	1,771		73.03
73.04	03950	DIETARY EDUCATION	0	566	0	566		73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	81,174	0	81,174		88.00
88.01	08801	RHC II -ONARGA CLINIC	0	18,128	0	18,128		88.01
88.02	08802	RHC III - FORREST CLINIC	0	24,271	0	24,271		88.02
88.03	08803	RHC IV - HOOPESTON	0	20,857	0	20,857		88.03
88.04	08804	RHC V - FARMER CITY	0	12,300	0	12,300		88.04
88.05	08805	RHC VI - GIBSON CITY	0	15,255	0	15,255		88.05
90.00	09000	CLINIC	284	37,065	0	37,065		90.00
90.01	09001	GERI PSYCH CLINIC	148	13,440	0	13,440		90.01
90.02	09002	ORTHO CLINIC	607	11,087	0	11,087		90.02
91.00	09100	EMERGENCY	3,611	149,305	0	149,305		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	93,976	0	93,976		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,081	2,139,344	0	2,139,344		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,855	0	4,855		190.00
192.01	19201	GAH - MSO	0	2,125	0	2,125		192.01
192.02	19202	GAH FOUNDATION	0	990	0	990		192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	4,970	0	4,970		194.00
194.01	07951	PHYSICIAN OFFICE	0	34,043	0	34,043		194.01
194.02	07952	PHYSICIAN CLINICS	0	9,294	0	9,294		194.02
194.03	07953	WELLNESS CENTER	0	19,100	0	19,100		194.03
194.04	07954	PSYCH CLINIC	0	1,287	0	1,287		194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	6,572	0	6,572		194.05
194.06	07956	LASER CLINIC	0	40	0	40		194.06
194.07	07957	PAIN CLINIC	0	432	0	432		194.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
194.08	07958	340B PHARMACY	0	1,181	0	1,181		194.08
194.09	07959	GAH CARDIOLOGY	0	2,365	0	2,365		194.09
194.10	07960	WIC	0	853	0	853		194.10
194.11	07961	PULMONARY CLINIC	0	2	0	2		194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	11,401	0	11,401		194.12
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	18,081	2,238,854	0	2,238,854		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	129,478					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		687,429				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	646	0	24,035,175			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	523	0	1,107,774	-2,157,597	43,663,431	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	14,348	106,892	3,262,474	0	8,353,172	5.02
7.00	00700	OPERATION OF PLANT	35,989	1,991	635,908	0	2,672,610	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,719	6,218	119,007	0	236,228	8.00
9.00	00900	HOUSEKEEPING	548	0	298,559	0	480,266	9.00
10.00	01000	DIETARY	2,511	7,182	194,887	0	337,215	10.00
11.00	01100	CAFETERIA	797	0	256,143	0	454,818	11.00
13.00	01300	NURSING ADMINISTRATION	298	0	287,376	0	551,720	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	704	0	0	0	79,434	14.00
15.00	01500	PHARMACY	1,325	0	386,022	0	649,573	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,031	75	316,989	0	494,344	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,244	36,481	2,262,043	0	3,547,778	30.00
31.00	03100	INTENSIVE CARE UNIT	970	0	579,842	0	801,309	31.00
43.00	04300	NURSERY	319	0	435,170	0	639,636	43.00
44.00	04400	SKILLED NURSING FACILITY	1,145	0	73,453	-120,161	0	44.00
46.00	04600	OTHER LONG TERM CARE	12,233	8,386	1,412,843	-2,206,949	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,131	125,412	1,714,751	0	3,370,220	50.00
51.00	05100	RECOVERY ROOM	1,263	308	311,321	0	475,005	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,080	0	140,790	0	218,247	52.00
53.00	05300	ANESTHESIOLOGY	98	13,344	0	0	265,025	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,227	201,787	950,463	0	3,303,595	54.00
56.00	05600	RADIOISOTOPE	659	0	105,111	0	267,742	56.00
60.00	06000	LABORATORY	1,877	26,965	771,683	0	1,957,766	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	154	0	0	0	148,408	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	451	8,840	419,517	0	652,934	65.00
66.00	06600	PHYSICAL THERAPY	10,649	13,842	1,459,269	0	2,312,480	66.00
67.00	06700	OCCUPATIONAL THERAPY	225	0	152,255	0	215,513	67.00
68.00	06800	SPEECH PATHOLOGY	225	0	51	0	61,288	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,670	0	0	6,224	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	841,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,039,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,249,331	73.00
73.01	07301	CARDIAC REHAB	1,011	4,350	85,936	0	142,286	73.01
73.02	07302	WOUND CARE	669	0	156,643	0	230,130	73.02
73.03	07303	SLEEP LAB	0	86	81,773	0	219,747	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	98,981	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	9,283	774,677	-3,826,243	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	220,949	-960,004	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	2,953	334,845	-1,608,789	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	10,000	208,676	-906,260	0	88.03
88.04	08804	RHC V - FARMER CITY	0	3,040	113,608	-637,494	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	182,446	-791,875	0	88.05
90.00	09000	CLINIC	2,371	0	259,586	0	418,843	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	186,735	0	421,983	90.01
90.02	09002	ORTHO CLINIC	0	0	163,924	0	509,512	90.02
91.00	09100	EMERGENCY	6,699	30,049	1,177,700	0	2,344,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	46,439	1,777,978	-2,814,289	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	129,139	666,593	23,379,177	-16,029,661	42,068,866	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	-3,924	0	190.00
192.01	19201	GAH - MSO	0	0	179,758	-389,715	0	192.01
192.02	19202	GAH FOUNDATION	0	0	10,654	-186,132	0	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	0	3,650	194.00
194.01	07951	PHYSICIAN OFFICE	0	20,836	107,233	-764,893	0	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	3,971	-949,910	0	194.02
194.03	07953	WELLNESS CENTER	0	0	96,173	-206,605	0	194.03
194.04	07954	PSYCH CLINIC	0	0	12,229	0	224,472	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	0	30,686	0	145,226	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
194.06	07956	LASER CLINIC	0	0	290	0	6,994	194.06
194.07	07957	PAIN CLINIC	0	0	206	0	75,619	194.07
194.08	07958	340B PHARMACY	0	0	0	0	206,795	194.08
194.09	07959	GAH CARDIOLOGY	0	0	8,019	0	412,919	194.09
194.10	07960	WIC	0	0	100,523	0	143,673	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	303	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	0	106,256	0	374,914	194.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,498,677	740,177	8,321,984		2,157,597	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.574762	1.076732	0.346242		0.049414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,477		6,399	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000311		0.000147	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	-8,765,948	53,428,323				5.02
7.00	00700	OPERATION OF PLANT	0	2,804,674	169,139			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	247,901	1,719	340,748		8.00
9.00	00900	HOUSEKEEPING	0	503,998	548	31,035	115,739	9.00
10.00	01000	DIETARY	0	353,878	2,511	3,824	2,511	10.00
11.00	01100	CAFETERIA	0	477,292	797	6,731	797	11.00
13.00	01300	NURSING ADMINISTRATION	0	578,983	298	0	298	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	83,359	704	0	704	14.00
15.00	01500	PHARMACY	0	681,671	1,325	0	1,325	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	518,772	1,031	0	1,031	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,723,088	13,244	72,644	13,244	30.00
31.00	03100	INTENSIVE CARE UNIT	0	840,905	970	0	970	31.00
43.00	04300	NURSERY	0	671,243	319	2,848	319	43.00
44.00	04400	SKILLED NURSING FACILITY	0	120,161	1,145	17,480	1,145	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,206,949	12,233	99,173	12,233	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,536,756	6,131	36,722	6,131	50.00
51.00	05100	RECOVERY ROOM	0	498,477	1,263	0	1,263	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	229,031	1,080	11,744	1,080	52.00
53.00	05300	ANESTHESIOLOGY	0	278,121	2,072	0	2,072	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,466,839	7,227	13,348	7,227	54.00
56.00	05600	RADIOISOTOPE	0	280,972	659	0	659	56.00
60.00	06000	LABORATORY	0	2,054,507	1,877	0	1,877	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	155,741	154	0	154	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	685,198	451	0	451	65.00
66.00	06600	PHYSICAL THERAPY	0	2,426,749	27,214	16,940	27,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	226,162	225	0	225	67.00
68.00	06800	SPEECH PATHOLOGY	0	64,316	225	0	225	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,532	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	883,345	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,189,290	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,311,065	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	149,317	1,011	0	1,011	73.01
73.02	07302	WOUND CARE	0	241,502	669	0	669	73.02
73.03	07303	SLEEP LAB	0	230,606	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	103,872	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	3,826,243	19,415	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	960,004	5,000	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,608,789	4,708	0	1,424	88.02
88.03	08803	RHC IV - HOOPESTON	0	906,260	2,000	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	637,494	2,160	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	791,875	4,032	0	4,032	88.05
90.00	09000	CLINIC	0	439,540	2,371	0	2,371	90.00
90.01	09001	GERI PSYCH CLINIC	0	442,835	4,032	0	4,032	90.01
90.02	09002	ORTHO CLINIC	0	534,689	2,295	0	2,295	90.02
91.00	09100	EMERGENCY	0	2,460,495	6,699	28,259	6,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,814,289	10,074	0	3,228	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,765,948	49,253,785	149,888	340,748	108,916	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,924	339	0	339	190.00
192.01	19201	GAH - MSO	0	389,715	0	0	0	192.01
192.02	19202	GAH FOUNDATION	0	186,132	0	0	0	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	3,830	1,928	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	764,893	2,800	0	2,800	194.01
194.02	07952	PHYSICIAN CLINICS	0	949,910	1,554	0	1,554	194.02
194.03	07953	WELLNESS CENTER	0	206,605	7,000	0	0	194.03
194.04	07954	PSYCH CLINIC	0	235,564	0	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	152,402	2,130	0	2,130	194.05
194.06	07956	LASER CLINIC	0	7,340	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	79,356	0	0	0	194.07
194.08	07958	340B PHARMACY	0	217,014	0	0	0	194.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
194.09	07959	GAH CARDIOLOGY	0	433,323	0	0	0	194.09
194.10	07960	WIC	0	150,772	0	0	0	194.10
194.11	07961	PULMONARY CLINIC	0	318	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	393,440	3,500	0	0	194.12
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)		8,765,948	3,264,834	321,755	626,571	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.164069	19.302668	0.944261	5.413655	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		283,390	434,173	32,392	13,537	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005304	2.566960	0.095061	0.116961	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	48,606					10.00
11.00	01100	CAFETERIA	0	31,436				11.00
13.00	01300	NURSING ADMINISTRATION	0	385	326,125			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	4,751,554		14.00
15.00	01500	PHARMACY	0	194	0	4,254	1,437,798	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	792	0	1,893	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,983	4,230	87,977	137,828	3,491	30.00
31.00	03100	INTENSIVE CARE UNIT	108	655	13,614	206	0	31.00
43.00	04300	NURSERY	0	632	13,141	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,854	170	3,531	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	35,661	3,265	67,918	33,030	299	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,806	58,368	408,140	10,746	50.00
51.00	05100	RECOVERY ROOM	0	694	14,440	24,345	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	204	4,252	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	364	0	36,698	16,103	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,673	0	16,583	4,810	54.00
56.00	05600	RADIOISOTOPE	0	465	0	1,193	77	56.00
60.00	06000	LABORATORY	0	2,019	0	40,802	59	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	804	16,721	2,425	123	65.00
66.00	06600	PHYSICAL THERAPY	0	2,507	0	4,048	558	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	187	0	2	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	95	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	841,754	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,039,115	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,249,331	73.00
73.01	07301	CARDIAC REHAB	0	142	2,963	575	0	73.01
73.02	07302	WOUND CARE	0	163	3,385	5,513	79	73.02
73.03	07303	SLEEP LAB	0	163	3,383	262	211	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	0	15,978	48,078	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	5,836	7,499	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0	9,447	11,407	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0	2,044	4,984	88.03
88.04	08804	RHC V - FARMER CITY	0	0	0	2,130	3,839	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0	9,146	9,858	88.05
90.00	09000	CLINIC	0	489	10,173	10,813	561	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	679	0	90.01
90.02	09002	ORTHO CLINIC	0	1,599	0	4,729	37,952	90.02
91.00	09100	EMERGENCY	0	1,262	26,259	68,950	859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,572	0	10,441	6,022	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,606	31,436	326,125	4,738,954	1,416,946	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.01	19201	GAH - MSO	0	0	0	945	0	192.01
192.02	19202	GAH FOUNDATION	0	0	0	0	0	192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	0	0	1,031	97	194.01
194.02	07952	PHYSICIAN CLINICS	0	0	0	1,558	5,124	194.02
194.03	07953	WELLNESS CENTER	0	0	0	2,330	0	194.03
194.04	07954	PSYCH CLINIC	0	0	0	278	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	0	0	2,741	637	194.05
194.06	07956	LASER CLINIC	0	0	0	8	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	0	0	194.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
194.08	07958	340B PHARMACY	0	0	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	0	0	0	7	227	194.09
194.10	07960	WIC	0	0	0	284	0	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	0	0	3,418	14,767	194.12
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)	477,612	581,656	688,465	114,436	829,953	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.826194	18.502863	2.111046	0.024084	0.577239	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,889	14,683	7,670	10,492	22,824	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.944102	0.467076	0.023519	0.002208	0.015874	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL			5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL			5.02
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	167,760		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	26,945		30.00
31.00	03100	INTENSIVE CARE UNIT	510		31.00
43.00	04300	NURSERY	270		43.00
44.00	04400	SKILLED NURSING FACILITY	2,980		44.00
46.00	04600	OTHER LONG TERM CARE	0		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	30,075		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,865		54.00
56.00	05600	RADIOISOTOPE	0		56.00
60.00	06000	LABORATORY	11,921		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	3,430		65.00
66.00	06600	PHYSICAL THERAPY	1,860		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
73.01	07301	CARDIAC REHAB	1,000		73.01
73.02	07302	WOUND CARE	2,550		73.02
73.03	07303	SLEEP LAB	2,210		73.03
73.04	03950	DIETARY EDUCATION	0		73.04
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC - PAXTON CLINIC	0		88.00
88.01	08801	RHC II -ONARGA CLINIC	0		88.01
88.02	08802	RHC III - FORREST CLINIC	0		88.02
88.03	08803	RHC IV - HOOPESTON	0		88.03
88.04	08804	RHC V - FARMER CITY	0		88.04
88.05	08805	RHC VI - GIBSON CITY	0		88.05
90.00	09000	CLINIC	2,639		90.00
90.01	09001	GERI PSYCH CLINIC	1,370		90.01
90.02	09002	ORTHO CLINIC	5,630		90.02
91.00	09100	EMERGENCY	33,505		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	167,760		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.01	19201	GAH - MSO	0		192.01
192.02	19202	GAH FOUNDATION	0		192.02
194.00	07950	HOSPITAL ASSOC SRVCS	0		194.00
194.01	07951	PHYSICIAN OFFICE	0		194.01
194.02	07952	PHYSICIAN CLINICS	0		194.02
194.03	07953	WELLNESS CENTER	0		194.03
194.04	07954	PSYCH CLINIC	0		194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0		194.05
194.06	07956	LASER CLINIC	0		194.06
194.07	07957	PAIN CLINIC	0		194.07
194.08	07958	340B PHARMACY	0		194.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/24/2015 4:07 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			16.00		
194.09	07959	GAH CARDIOLOGY	0		194.09
194.10	07960	WIC	0		194.10
194.11	07961	PULMONARY CLINIC	0		194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0		194.12
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)	644,068		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.839223		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,081		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.107779		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-2 | Date/Time Prepared: 2/24/2015 4:07 pm

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY RECLASS	1	30.00	-26,987	7.00
8.00		IV THERAPY RECLASS	1	64.00	26,987	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/24/2015 4:07 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	5,183,574		5,183,574	0	5,183,574	30.00
31.00	03100	INTENSIVE CARE UNIT	1,046,729		1,046,729	0	1,046,729	31.00
43.00	04300	NURSERY	832,419		832,419	0	832,419	43.00
44.00	04400	SKILLED NURSING FACILITY	224,941		224,941	0	224,941	44.00
46.00	04600	OTHER LONG TERM CARE	3,520,211		3,520,211	0	3,520,211	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,609,874		4,609,874	0	4,609,874	50.00
51.00	05100	RECOVERY ROOM	655,389		655,389	0	655,389	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,142		317,142	0	317,142	52.00
53.00	05300	ANESTHESIOLOGY	391,878		391,878	0	391,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,436,390		4,436,390	0	4,436,390	54.00
56.00	05600	RADIOISOTOPE	352,036		352,036	0	352,036	56.00
60.00	06000	LABORATORY	2,522,121		2,522,121	0	2,522,121	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	185,100		185,100	0	185,100	63.00
64.00	06400	INTRAVENOUS THERAPY	26,987		26,987	0	26,987	64.00
65.00	06500	RESPIRATORY THERAPY	872,239	0	872,239	0	872,239	65.00
66.00	06600	PHYSICAL THERAPY	3,567,477	0	3,567,477	0	3,567,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	272,289	0	272,289	0	272,289	67.00
68.00	06800	SPEECH PATHOLOGY	80,429	0	80,429	0	80,429	68.00
69.00	06900	ELECTROCARDIOLOGY	7,606		7,606	0	7,606	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,048,548		1,048,548	0	1,048,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,785,749		3,785,749	0	3,785,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,247,332		2,247,332	0	2,247,332	73.00
73.01	07301	CARDIAC REHAB	211,538		211,538	0	211,538	73.01
73.02	07302	WOUND CARE	317,791		317,791	0	317,791	73.02
73.03	07303	SLEEP LAB	287,212		287,212	0	287,212	73.03
73.04	03950	DIETARY EDUCATION	120,914		120,914	0	120,914	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	4,856,929		4,856,929	0	4,856,929	88.00
88.01	08801	RHC II -ONARGA CLINIC	1,218,494		1,218,494	0	1,218,494	88.01
88.02	08802	RHC III - FORREST CLINIC	1,978,140		1,978,140	0	1,978,140	88.02
88.03	08803	RHC IV - HOOPESTON	1,096,480		1,096,480	0	1,096,480	88.03
88.04	08804	RHC V - FARMER CITY	786,048		786,048	0	786,048	88.04
88.05	08805	RHC VI - GIBSON CITY	1,027,363		1,027,363	0	1,027,363	88.05
90.00	09000	CLINIC	611,498		611,498	0	611,498	90.00
90.01	09001	GERI PSYCH CLINIC	620,422		620,422	0	620,422	90.01
90.02	09002	ORTHO CLINIC	752,361		752,361	0	752,361	90.02
91.00	09100	EMERGENCY	3,266,020		3,266,020	0	3,266,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	522,301		522,301		522,301	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,576,279		3,576,279	0	3,576,279	95.00
200.00		Subtotal (see instructions)	57,436,250	0	57,436,250	0	57,436,250	200.00
201.00		Less Observation Beds	522,301		522,301		522,301	201.00
202.00		Total (see instructions)	56,913,949	0	56,913,949	0	56,913,949	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/24/2015 4:07 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	5,912,616		5,912,616			30.00
31.00	03100	INTENSIVE CARE UNIT	153,642		153,642			31.00
43.00	04300	NURSERY	477,201		477,201			43.00
44.00	04400	SKILLED NURSING FACILITY	164,088		164,088			44.00
46.00	04600	OTHER LONG TERM CARE	2,748,156		2,748,156			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,472,163	11,802,403	17,274,566	0.266859	0.000000	50.00
51.00	05100	RECOVERY ROOM	612,716	2,311,398	2,924,114	0.224133	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,617,143	295,136	1,912,279	0.165845	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	19,043	79,644	98,687	3.970918	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,391,567	20,701,348	22,092,915	0.200806	0.000000	54.00
56.00	05600	RADIOISOTOPE	41,716	1,720,531	1,762,247	0.199765	0.000000	56.00
60.00	06000	LABORATORY	1,617,746	11,252,737	12,870,483	0.195962	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	288,216	224,480	512,696	0.361033	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	8,000	342,580	350,580	0.076978	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,137,749	1,245,441	4,383,190	0.198996	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	775,685	5,219,711	5,995,396	0.595036	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	762,807	234,778	997,585	0.272948	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,279	98,140	112,419	0.715440	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	106,830	863,810	970,640	0.007836	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,210,424	3,178,309	5,388,733	0.194582	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,531,717	610,412	8,142,129	0.464958	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,193,516	7,976,199	13,169,715	0.170644	0.000000	73.00
73.01	07301	CARDIAC REHAB	0	262,509	262,509	0.805831	0.000000	73.01
73.02	07302	WOUND CARE	2,153	427,735	429,888	0.739241	0.000000	73.02
73.03	07303	SLEEP LAB	0	1,113,277	1,113,277	0.257988	0.000000	73.03
73.04	03950	DIETARY EDUCATION	67,620	31,361	98,981	1.221588	0.000000	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	5,000,288	5,000,288			88.00
88.01	08801	RHC II -ONARGA CLINIC	0	674,727	674,727			88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,492,121	1,492,121			88.02
88.03	08803	RHC IV - HOOPESTON	0	641,057	641,057			88.03
88.04	08804	RHC V - FARMER CITY	0	581,142	581,142			88.04
88.05	08805	RHC VI - GIBSON CITY	0	965,805	965,805			88.05
90.00	09000	CLINIC	90,000	508,646	598,646	1.021468	0.000000	90.00
90.01	09001	GERI PSYCH CLINIC	0	478,054	478,054	1.297807	0.000000	90.01
90.02	09002	ORTHO CLINIC	0	1,535,376	1,535,376	0.490017	0.000000	90.02
91.00	09100	EMERGENCY	7,174	7,999,944	8,007,118	0.407890	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,465	478,066	487,531	1.071319	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,698,330	4,698,330	0.761181	0.000000	95.00
200.00		Subtotal (see instructions)	40,433,432	95,045,495	135,478,927			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,433,432	95,045,495	135,478,927			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/24/2015 4:07 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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	07301	CARDIAC REHAB	0.000000	73.01
73.02	07302	WOUND CARE	0.000000	73.02
73.03	07303	SLEEP LAB	0.000000	73.03
73.04	03950	DIETARY EDUCATION	0.000000	73.04
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RHC - PAXTON CLINIC		88.00
88.01	08801	RHC II -ONARGA CLINIC		88.01
88.02	08802	RHC III - FORREST CLINIC		88.02
88.03	08803	RHC IV - HOOPESTON		88.03
88.04	08804	RHC V - FARMER CITY		88.04
88.05	08805	RHC VI - GIBSON CITY		88.05
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	GERI PSYCH CLINIC	0.000000	90.01
90.02	09002	ORTHO CLINIC	0.000000	90.02
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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/24/2015 4:07 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	5,183,574		5,183,574	0	5,183,574	30.00
31.00	03100	INTENSIVE CARE UNIT	1,046,729		1,046,729	0	1,046,729	31.00
43.00	04300	NURSERY	832,419		832,419	0	832,419	43.00
44.00	04400	SKILLED NURSING FACILITY	224,941		224,941	0	224,941	44.00
46.00	04600	OTHER LONG TERM CARE	3,520,211		3,520,211	0	3,520,211	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,609,874		4,609,874	0	4,609,874	50.00
51.00	05100	RECOVERY ROOM	655,389		655,389	0	655,389	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,142		317,142	0	317,142	52.00
53.00	05300	ANESTHESIOLOGY	391,878		391,878	0	391,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,436,390		4,436,390	0	4,436,390	54.00
56.00	05600	RADIOISOTOPE	352,036		352,036	0	352,036	56.00
60.00	06000	LABORATORY	2,522,121		2,522,121	0	2,522,121	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	185,100		185,100	0	185,100	63.00
64.00	06400	INTRAVENOUS THERAPY	26,987		26,987	0	26,987	64.00
65.00	06500	RESPIRATORY THERAPY	872,239	0	872,239	0	872,239	65.00
66.00	06600	PHYSICAL THERAPY	3,567,477	0	3,567,477	0	3,567,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	272,289	0	272,289	0	272,289	67.00
68.00	06800	SPEECH PATHOLOGY	80,429	0	80,429	0	80,429	68.00
69.00	06900	ELECTROCARDIOLOGY	7,606		7,606	0	7,606	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,048,548		1,048,548	0	1,048,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,785,749		3,785,749	0	3,785,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,247,332		2,247,332	0	2,247,332	73.00
73.01	07301	CARDIAC REHAB	211,538		211,538	0	211,538	73.01
73.02	07302	WOUND CARE	317,791		317,791	0	317,791	73.02
73.03	07303	SLEEP LAB	287,212		287,212	0	287,212	73.03
73.04	03950	DIETARY EDUCATION	120,914		120,914	0	120,914	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	4,856,929		4,856,929	0	4,856,929	88.00
88.01	08801	RHC II -ONARGA CLINIC	1,218,494		1,218,494	0	1,218,494	88.01
88.02	08802	RHC III - FORREST CLINIC	1,978,140		1,978,140	0	1,978,140	88.02
88.03	08803	RHC IV - HOOPESTON	1,096,480		1,096,480	0	1,096,480	88.03
88.04	08804	RHC V - FARMER CITY	786,048		786,048	0	786,048	88.04
88.05	08805	RHC VI - GIBSON CITY	1,027,363		1,027,363	0	1,027,363	88.05
90.00	09000	CLINIC	611,498		611,498	0	611,498	90.00
90.01	09001	GERI PSYCH CLINIC	620,422		620,422	0	620,422	90.01
90.02	09002	ORTHO CLINIC	752,361		752,361	0	752,361	90.02
91.00	09100	EMERGENCY	3,266,020		3,266,020	0	3,266,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	522,301		522,301		522,301	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,576,279		3,576,279	0	3,576,279	95.00
200.00		Subtotal (see instructions)	57,436,250	0	57,436,250	0	57,436,250	200.00
201.00		Less Observation Beds	522,301		522,301		522,301	201.00
202.00		Total (see instructions)	56,913,949	0	56,913,949	0	56,913,949	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/24/2015 4:07 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,912,616		5,912,616			30.00
31.00	03100	INTENSIVE CARE UNIT	153,642		153,642			31.00
43.00	04300	NURSERY	477,201		477,201			43.00
44.00	04400	SKILLED NURSING FACILITY	164,088		164,088			44.00
46.00	04600	OTHER LONG TERM CARE	2,748,156		2,748,156			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,472,163	11,802,403	17,274,566	0.266859	0.000000	50.00
51.00	05100	RECOVERY ROOM	612,716	2,311,398	2,924,114	0.224133	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,617,143	295,136	1,912,279	0.165845	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	19,043	79,644	98,687	3.970918	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,391,567	20,701,348	22,092,915	0.200806	0.000000	54.00
56.00	05600	RADIOISOTOPE	41,716	1,720,531	1,762,247	0.199765	0.000000	56.00
60.00	06000	LABORATORY	1,617,746	11,252,737	12,870,483	0.195962	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	288,216	224,480	512,696	0.361033	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	8,000	342,580	350,580	0.076978	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,137,749	1,245,441	4,383,190	0.198996	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	775,685	5,219,711	5,995,396	0.595036	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	762,807	234,778	997,585	0.272948	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,279	98,140	112,419	0.715440	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	106,830	863,810	970,640	0.007836	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,210,424	3,178,309	5,388,733	0.194582	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,531,717	610,412	8,142,129	0.464958	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,193,516	7,976,199	13,169,715	0.170644	0.000000	73.00
73.01	07301	CARDIAC REHAB	0	262,509	262,509	0.805831	0.000000	73.01
73.02	07302	WOUND CARE	2,153	427,735	429,888	0.739241	0.000000	73.02
73.03	07303	SLEEP LAB	0	1,113,277	1,113,277	0.257988	0.000000	73.03
73.04	03950	DIETARY EDUCATION	67,620	31,361	98,981	1.221588	0.000000	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	5,000,288	5,000,288	0.971330	0.000000	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	674,727	674,727	1.805907	0.000000	88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,492,121	1,492,121	1.325724	0.000000	88.02
88.03	08803	RHC IV - HOOPESTON	0	641,057	641,057	1.710425	0.000000	88.03
88.04	08804	RHC V - FARMER CITY	0	581,142	581,142	1.352592	0.000000	88.04
88.05	08805	RHC VI - GIBSON CITY	0	965,805	965,805	1.063738	0.000000	88.05
90.00	09000	CLINIC	90,000	508,646	598,646	1.021468	0.000000	90.00
90.01	09001	GERI PSYCH CLINIC	0	478,054	478,054	1.297807	0.000000	90.01
90.02	09002	ORTHO CLINIC	0	1,535,376	1,535,376	0.490017	0.000000	90.02
91.00	09100	EMERGENCY	7,174	7,999,944	8,007,118	0.407890	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,465	478,066	487,531	1.071319	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,698,330	4,698,330	0.761181	0.000000	95.00
200.00		Subtotal (see instructions)	40,433,432	95,045,495	135,478,927			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,433,432	95,045,495	135,478,927			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/24/2015 4:07 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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	CARDIAC REHAB	0.000000		73.01
73.02	07302	WOUND CARE	0.000000		73.02
73.03	07303	SLEEP LAB	0.000000		73.03
73.04	03950	DIETARY EDUCATION	0.000000		73.04
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC - PAXTON CLINIC	0.000000		88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000		88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000		88.02
88.03	08803	RHC IV - HOOPESTON	0.000000		88.03
88.04	08804	RHC V - FARMER CITY	0.000000		88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000		88.05
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	GERI PSYCH CLINIC	0.000000		90.01
90.02	09002	ORTHO CLINIC	0.000000		90.02
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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/24/2015 4:07 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	252,730	17,274,566	0.014630	2,334,912	34,160	50.00
51.00	05100	RECOVERY ROOM	21,870	2,924,114	0.007479	267,577	2,001	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,001	1,912,279	0.009413	0	0	52.00
53.00	05300	ANESTHESIOLOGY	23,084	98,687	0.233911	6,670	1,560	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	346,523	22,092,915	0.015685	739,648	11,601	54.00
56.00	05600	RADIOISOTOPE	11,180	1,762,247	0.006344	21,012	133	56.00
60.00	06000	LABORATORY	69,542	12,870,483	0.005403	869,967	4,700	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,044	512,696	0.005937	162,558	965	63.00
64.00	06400	INTRAVENOUS THERAPY	0	350,580	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,955	4,383,190	0.004781	1,918,611	9,173	65.00
66.00	06600	PHYSICAL THERAPY	227,866	5,995,396	0.038007	186,099	7,073	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,574	997,585	0.004585	195,308	895	67.00
68.00	06800	SPEECH PATHOLOGY	3,558	112,419	0.031649	5,566	176	68.00
69.00	06900	ELECTROCARDIOLOGY	2,911	970,640	0.002999	69,006	207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,668	5,388,733	0.001237	836,055	1,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,075	8,142,129	0.002957	3,795,493	11,223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,971	13,169,715	0.002048	2,406,100	4,928	73.00
73.01	07301	CARDIAC REHAB	20,184	262,509	0.076889	0	0	73.01
73.02	07302	WOUND CARE	11,347	429,888	0.026395	239	6	73.02
73.03	07303	SLEEP LAB	1,771	1,113,277	0.001591	0	0	73.03
73.04	03950	DIETARY EDUCATION	566	98,981	0.005718	1,188	7	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	81,174	5,000,288	0.016234	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	18,128	674,727	0.026867	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	24,271	1,492,121	0.016266	0	0	88.02
88.03	08803	RHC IV - HOOPESTON	20,857	641,057	0.032535	0	0	88.03
88.04	08804	RHC V - FARMER CITY	12,300	581,142	0.021165	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	15,255	965,805	0.015795	0	0	88.05
90.00	09000	CLINIC	37,065	598,646	0.061915	31,432	1,946	90.00
90.01	09001	GERI PSYCH CLINIC	13,440	478,054	0.028114	0	0	90.01
90.02	09002	ORTHO CLINIC	11,087	1,535,376	0.007221	0	0	90.02
91.00	09100	EMERGENCY	149,305	8,007,118	0.018647	85	2	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	34,365	487,531	0.070488	2,939	207	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,514,667	121,324,894		13,850,465	91,997	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/24/2015 4:07 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	0	0	0	73.01
73.02	07302	WOUND CARE	0	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	0	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0	0	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	0	0	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/24/2015 4:07 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	17,274,566	0.000000	0.000000	2,334,912	50.00
51.00	05100	RECOVERY ROOM	0	2,924,114	0.000000	0.000000	267,577	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,912,279	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	98,687	0.000000	0.000000	6,670	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,092,915	0.000000	0.000000	739,648	54.00
56.00	05600	RADIOISOTOPE	0	1,762,247	0.000000	0.000000	21,012	56.00
60.00	06000	LABORATORY	0	12,870,483	0.000000	0.000000	869,967	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	512,696	0.000000	0.000000	162,558	63.00
64.00	06400	INTRAVENOUS THERAPY	0	350,580	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,383,190	0.000000	0.000000	1,918,611	65.00
66.00	06600	PHYSICAL THERAPY	0	5,995,396	0.000000	0.000000	186,099	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	997,585	0.000000	0.000000	195,308	67.00
68.00	06800	SPEECH PATHOLOGY	0	112,419	0.000000	0.000000	5,566	68.00
69.00	06900	ELECTROCARDIOLOGY	0	970,640	0.000000	0.000000	69,006	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,388,733	0.000000	0.000000	836,055	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,142,129	0.000000	0.000000	3,795,493	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,169,715	0.000000	0.000000	2,406,100	73.00
73.01	07301	CARDIAC REHAB	0	262,509	0.000000	0.000000	0	73.01
73.02	07302	WOUND CARE	0	429,888	0.000000	0.000000	239	73.02
73.03	07303	SLEEP LAB	0	1,113,277	0.000000	0.000000	0	73.03
73.04	03950	DIETARY EDUCATION	0	98,981	0.000000	0.000000	1,188	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	5,000,288	0.000000	0.000000	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	674,727	0.000000	0.000000	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,492,121	0.000000	0.000000	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	641,057	0.000000	0.000000	0	88.03
88.04	08804	RHC V - FARMER CITY	0	581,142	0.000000	0.000000	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	965,805	0.000000	0.000000	0	88.05
90.00	09000	CLINIC	0	598,646	0.000000	0.000000	31,432	90.00
90.01	09001	GERI PSYCH CLINIC	0	478,054	0.000000	0.000000	0	90.01
90.02	09002	ORTHO CLINIC	0	1,535,376	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	8,007,118	0.000000	0.000000	85	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	487,531	0.000000	0.000000	2,939	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	121,324,894			13,850,465	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/24/2015 4:07 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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	07301	CARDIAC REHAB	0	0	0		73.01
73.02	07302	WOUND CARE	0	0	0		73.02
73.03	07303	SLEEP LAB	0	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - PAXTON CLINIC	0	0	0		88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0		88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0		88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0		88.03
88.04	08804	RHC V - FARMER CITY	0	0	0		88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0		88.05
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0		90.01
90.02	09002	ORTHO CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/24/2015 4:07 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	0.266859	0	4,089,655	0	0	50.00
51.00	05100	RECOVERY ROOM	0.224133	0	834,643	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165845	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3.970918	0	21,635	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200806	0	6,540,377	0	0	54.00
56.00	05600	RADIOISOTOPE	0.199765	0	672,732	0	0	56.00
60.00	06000	LABORATORY	0.195962	0	4,892,411	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.361033	0	141,388	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.076978	0	293,712	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.198996	0	561,483	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.595036	0	1,554,750	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272948	0	121,822	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.715440	0	23,805	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007836	0	360,889	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194582	0	925,009	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.464958	0	172,320	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170644	0	3,326,264	4,394	0	73.00
73.01	07301	CARDIAC REHAB	0.805831	0	77,840	0	0	73.01
73.02	07302	WOUND CARE	0.739241	0	176,005	0	0	73.02
73.03	07303	SLEEP LAB	0.257988	0	315,065	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.221588	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0.000000				0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000				0	88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000				0	88.02
88.03	08803	RHC IV - HOOPESTON	0.000000				0	88.03
88.04	08804	RHC V - FARMER CITY	0.000000				0	88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000				0	88.05
90.00	09000	CLINIC	1.021468	0	260,320	1,965	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.297807	0	445,086	0	0	90.01
90.02	09002	ORTHO CLINIC	0.490017	0	49,122	0	0	90.02
91.00	09100	EMERGENCY	0.407890	0	2,194,880	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.071319	0	197,129	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.761181		0			95.00
200.00		Subtotal (see instructions)		0	28,248,342	6,359	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	28,248,342	6,359	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/24/2015 4:07 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	1,091,361	0		50.00
51.00	05100	RECOVERY ROOM	187,071	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	85,911	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,313,347	0		54.00
56.00	05600	RADIOISOTOPE	134,388	0		56.00
60.00	06000	LABORATORY	958,727	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	51,046	0		63.00
64.00	06400	INTRAVENOUS THERAPY	22,609	0		64.00
65.00	06500	RESPIRATORY THERAPY	111,733	0		65.00
66.00	06600	PHYSICAL THERAPY	925,132	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	33,251	0		67.00
68.00	06800	SPEECH PATHOLOGY	17,031	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,828	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	179,990	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,122	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	567,607	750		73.00
73.01	07301	CARDIAC REHAB	62,726	0		73.01
73.02	07302	WOUND CARE	130,110	0		73.02
73.03	07303	SLEEP LAB	81,283	0		73.03
73.04	03950	DIETARY EDUCATION	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - PAXTON CLINIC	0	0		88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0		88.01
88.02	08802	RHC III - FORREST CLINIC	0	0		88.02
88.03	08803	RHC IV - HOOPESTON	0	0		88.03
88.04	08804	RHC V - FARMER CITY	0	0		88.04
88.05	08805	RHC VI - GIBSON CITY	0	0		88.05
90.00	09000	CLINIC	265,909	2,007		90.00
90.01	09001	GERI PSYCH CLINIC	577,636	0		90.01
90.02	09002	ORTHO CLINIC	24,071	0		90.02
91.00	09100	EMERGENCY	895,270	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	211,188	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	8,010,347	2,757		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	8,010,347	2,757		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141317 | Component CCN: 14Z317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/24/2015 4:07 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	0.266859	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.224133	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165845	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3.970918	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200806	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.199765	0	0	0	0	56.00
60.00	06000	LABORATORY	0.195962	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.361033	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.076978	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.198996	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.595036	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272948	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.715440	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007836	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194582	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.464958	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170644	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0.805831	0	0	0	0	73.01
73.02	07302	WOUND CARE	0.739241	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0.257988	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.221588	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0.000000				0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000				0	88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000				0	88.02
88.03	08803	RHC IV - HOOPESTON	0.000000				0	88.03
88.04	08804	RHC V - FARMER CITY	0.000000				0	88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000				0	88.05
90.00	09000	CLINIC	1.021468	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.297807	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0.490017	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.407890	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.071319	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.761181		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: 141317 | Component CCN: 14Z317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/24/2015 4:07 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
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	73.01
73.02	07302	WOUND CARE	0	0	73.02
73.03	07303	SLEEP LAB	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC - PAXTON CLINIC	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	88.05
90.00	09000	CLINIC	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	90.02
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: 141317 | Component CCN: 145979 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/24/2015 4:07 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	0	0	0	73.01
73.02	07302	WOUND CARE	0	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	0	0	0	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0	0	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0	0	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0	0	0	88.03
88.04	08804	RHC V - FARMER CITY	0	0	0	0	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		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: 141317 | Component CCN: 145979 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/24/2015 4:07 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	17,274,566	0.000000	0.000000	440	50.00
51.00	05100	RECOVERY ROOM	0	2,924,114	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,912,279	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	98,687	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,092,915	0.000000	0.000000	18,547	54.00
56.00	05600	RADIOISOTOPE	0	1,762,247	0.000000	0.000000	18	56.00
60.00	06000	LABORATORY	0	12,870,483	0.000000	0.000000	28,153	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	512,696	0.000000	0.000000	1,295	63.00
64.00	06400	INTRAVENOUS THERAPY	0	350,580	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,383,190	0.000000	0.000000	2,011	65.00
66.00	06600	PHYSICAL THERAPY	0	5,995,396	0.000000	0.000000	115,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	997,585	0.000000	0.000000	185,528	67.00
68.00	06800	SPEECH PATHOLOGY	0	112,419	0.000000	0.000000	1,697	68.00
69.00	06900	ELECTROCARDIOLOGY	0	970,640	0.000000	0.000000	2,968	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,388,733	0.000000	0.000000	907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,142,129	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,169,715	0.000000	0.000000	65,774	73.00
73.01	07301	CARDIAC REHAB	0	262,509	0.000000	0.000000	0	73.01
73.02	07302	WOUND CARE	0	429,888	0.000000	0.000000	344	73.02
73.03	07303	SLEEP LAB	0	1,113,277	0.000000	0.000000	0	73.03
73.04	03950	DIETARY EDUCATION	0	98,981	0.000000	0.000000	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0	5,000,288	0.000000	0.000000	0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0	674,727	0.000000	0.000000	0	88.01
88.02	08802	RHC III - FORREST CLINIC	0	1,492,121	0.000000	0.000000	0	88.02
88.03	08803	RHC IV - HOOPESTON	0	641,057	0.000000	0.000000	0	88.03
88.04	08804	RHC V - FARMER CITY	0	581,142	0.000000	0.000000	0	88.04
88.05	08805	RHC VI - GIBSON CITY	0	965,805	0.000000	0.000000	0	88.05
90.00	09000	CLINIC	0	598,646	0.000000	0.000000	582	90.00
90.01	09001	GERI PSYCH CLINIC	0	478,054	0.000000	0.000000	0	90.01
90.02	09002	ORTHO CLINIC	0	1,535,376	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	8,007,118	0.000000	0.000000	122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	487,531	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	121,324,894			423,733	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/24/2015 4:07 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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	07301	CARDIAC REHAB	0	0	0		73.01
73.02	07302	WOUND CARE	0	0	0		73.02
73.03	07303	SLEEP LAB	0	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - PAXTON CLINIC	0	0	0		88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0	0		88.01
88.02	08802	RHC III - FORREST CLINIC	0	0	0		88.02
88.03	08803	RHC IV - HOOPESTON	0	0	0		88.03
88.04	08804	RHC V - FARMER CITY	0	0	0		88.04
88.05	08805	RHC VI - GIBSON CITY	0	0	0		88.05
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0		90.01
90.02	09002	ORTHO CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		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: 141317 | Component CCN: 145979 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/24/2015 4:07 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.266859	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.224133	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165845	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3.970918	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200806	0	0	4	0	54.00
56.00	05600	RADIOISOTOPE	0.199765	0	0	5	0	56.00
60.00	06000	LABORATORY	0.195962	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.361033	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.076978	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.198996	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.595036	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272948	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.715440	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007836	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194582	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.464958	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170644	0	0	391	0	73.00
73.01	07301	CARDIAC REHAB	0.805831	0	0	0	0	73.01
73.02	07302	WOUND CARE	0.739241	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0.257988	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.221588	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - PAXTON CLINIC	0.000000				0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000				0	88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000				0	88.02
88.03	08803	RHC IV - HOOPESTON	0.000000				0	88.03
88.04	08804	RHC V - FARMER CITY	0.000000				0	88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000				0	88.05
90.00	09000	CLINIC	1.021468	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.297807	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0.490017	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.407890	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.071319	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.761181		0			95.00
200.00		Subtotal (see instructions)		0	0	400	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	400	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/24/2015 4:07 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1		54.00
56.00	05600	RADIOISOTOPE	0	1		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	67		73.00
73.01	07301	CARDIAC REHAB	0	0		73.01
73.02	07302	WOUND CARE	0	0		73.02
73.03	07303	SLEEP LAB	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - PAXTON CLINIC	0	0		88.00
88.01	08801	RHC II -ONARGA CLINIC	0	0		88.01
88.02	08802	RHC III - FORREST CLINIC	0	0		88.02
88.03	08803	RHC IV - HOOPESTON	0	0		88.03
88.04	08804	RHC V - FARMER CITY	0	0		88.04
88.05	08805	RHC VI - GIBSON CITY	0	0		88.05
90.00	09000	CLINIC	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0		90.01
90.02	09002	ORTHO CLINIC	0	0		90.02
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	69		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	69		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/24/2015 4:07 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)	3,661	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,851	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,493	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	173	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)	518	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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)	89	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,272	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)	131	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)	391	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	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,183,574	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)	4,036	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)	11,974	25.00
26.00	Total swing-bed cost (see instructions)	1,024,138	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,159,436	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,159,436	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,458.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,855,772	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,855,772	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/24/2015 4:07 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,046,729	72	14,537.90	59	857,736	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)	4,016,739	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,730,247	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)	191,121	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	570,446	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	761,567	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)	358	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,458.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	522,301	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/24/2015 4:07 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	273,676	4,159,436	0.065796	522,301	34,365	90.00
91.00	Nursing School cost	0	4,159,436	0.000000	522,301	0	91.00
92.00	Allied health cost	0	4,159,436	0.000000	522,301	0	92.00
93.00	All other Medical Education	0	4,159,436	0.000000	522,301	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 2/24/2015 4:07 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)	618	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	618	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)	618	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)	569	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	224,941	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)	224,941	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)	224,941	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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1

Component CCN: 145979 | Date/Time Prepared: 2/24/2015 4:07 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)	224,941	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	363.98	71.00
72.00	Program routine service cost (line 9 x line 71)	207,105	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)	207,105	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)	207,105	83.00
84.00	Program inpatient ancillary services (see instructions)	143,040	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)	350,145	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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1

Component CCN: 145979 | Date/Time Prepared: 2/24/2015 4:07 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/24/2015 4:07 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,310,450		30.00
31.00	03100	INTENSIVE CARE UNIT		125,911		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266859	2,334,912	623,092	50.00
51.00	05100	RECOVERY ROOM	0.224133	267,577	59,973	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165845	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3.970918	6,670	26,486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200806	739,648	148,526	54.00
56.00	05600	RADIOISOTOPE	0.199765	21,012	4,197	56.00
60.00	06000	LABORATORY	0.195962	869,967	170,480	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.361033	162,558	58,689	63.00
64.00	06400	INTRAVENOUS THERAPY	0.076978	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.198996	1,918,611	381,796	65.00
66.00	06600	PHYSICAL THERAPY	0.595036	186,099	110,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272948	195,308	53,309	67.00
68.00	06800	SPEECH PATHOLOGY	0.715440	5,566	3,982	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007836	69,006	541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194582	836,055	162,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.464958	3,795,493	1,764,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170644	2,406,100	410,587	73.00
73.01	07301	CARDIAC REHAB	0.805831	0	0	73.01
73.02	07302	WOUND CARE	0.739241	239	177	73.02
73.03	07303	SLEEP LAB	0.257988	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.221588	1,188	1,451	73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - PAXTON CLINIC	0.000000		0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000		0	88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000		0	88.02
88.03	08803	RHC IV - HOOPESTON	0.000000		0	88.03
88.04	08804	RHC V - FARMER CITY	0.000000		0	88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000		0	88.05
90.00	09000	CLINIC	1.021468	31,432	32,107	90.00
90.01	09001	GERI PSYCH CLINIC	1.297807	0	0	90.01
90.02	09002	ORTHO CLINIC	0.490017	0	0	90.02
91.00	09100	EMERGENCY	0.407890	85	35	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.071319	2,939	3,149	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		13,850,465	4,016,739	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)		13,850,465		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141317 | Component CCN: 14Z317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/24/2015 4:07 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266859	4,436	1,184	50.00
51.00	05100	RECOVERY ROOM	0.224133	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165845	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3.970918	35	139	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200806	41,412	8,316	54.00
56.00	05600	RADIOISOTOPE	0.199765	1,954	390	56.00
60.00	06000	LABORATORY	0.195962	117,662	23,057	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.361033	28,997	10,469	63.00
64.00	06400	INTRAVENOUS THERAPY	0.076978	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.198996	237,199	47,202	65.00
66.00	06600	PHYSICAL THERAPY	0.595036	118,127	70,290	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272948	133,576	36,459	67.00
68.00	06800	SPEECH PATHOLOGY	0.715440	3,648	2,610	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007836	3,645	29	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194582	80,591	15,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.464958	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170644	383,561	65,452	73.00
73.01	07301	CARDIAC REHAB	0.805831	0	0	73.01
73.02	07302	WOUND CARE	0.739241	344	254	73.02
73.03	07303	SLEEP LAB	0.257988	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.221588	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - PAXTON CLINIC	0.000000		0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000		0	88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000		0	88.02
88.03	08803	RHC IV - HOOPESTON	0.000000		0	88.03
88.04	08804	RHC V - FARMER CITY	0.000000		0	88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000		0	88.05
90.00	09000	CLINIC	1.021468	4,158	4,247	90.00
90.01	09001	GERI PSYCH CLINIC	1.297807	0	0	90.01
90.02	09002	ORTHO CLINIC	0.490017	0	0	90.02
91.00	09100	EMERGENCY	0.407890	122	50	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.071319	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)		1,159,467	285,830	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)		1,159,467		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/24/2015 4:07 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.266859	440	117	50.00
51.00	05100	RECOVERY ROOM	0.224133	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.165845	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3.970918	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200806	18,547	3,724	54.00
56.00	05600	RADIOISOTOPE	0.199765	18	4	56.00
60.00	06000	LABORATORY	0.195962	28,153	5,517	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.361033	1,295	468	63.00
64.00	06400	INTRAVENOUS THERAPY	0.076978	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.198996	2,011	400	65.00
66.00	06600	PHYSICAL THERAPY	0.595036	115,347	68,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.272948	185,528	50,639	67.00
68.00	06800	SPEECH PATHOLOGY	0.715440	1,697	1,214	68.00
69.00	06900	ELECTROCARDIOLOGY	0.007836	2,968	23	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194582	907	176	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.464958	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.170644	65,774	11,224	73.00
73.01	07301	CARDIAC REHAB	0.805831	0	0	73.01
73.02	07302	WOUND CARE	0.739241	344	254	73.02
73.03	07303	SLEEP LAB	0.257988	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.221588	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - PAXTON CLINIC	0.000000		0	88.00
88.01	08801	RHC II -ONARGA CLINIC	0.000000		0	88.01
88.02	08802	RHC III - FORREST CLINIC	0.000000		0	88.02
88.03	08803	RHC IV - HOOPESTON	0.000000		0	88.03
88.04	08804	RHC V - FARMER CITY	0.000000		0	88.04
88.05	08805	RHC VI - GIBSON CITY	0.000000		0	88.05
90.00	09000	CLINIC	1.021468	582	594	90.00
90.01	09001	GERI PSYCH CLINIC	1.297807	0	0	90.01
90.02	09002	ORTHO CLINIC	0.490017	0	0	90.02
91.00	09100	EMERGENCY	0.407890	122	50	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.071319	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)		423,733	143,040	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)		423,733		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/24/2015 4:07 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,013,104	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)	8,013,104	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)	8,093,235	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	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)	52,855	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,683,019	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,357,361	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,357,361	30.00
31.00	Primary payer payments	303	31.00
32.00	Subtotal (line 30 minus line 31)	3,357,058	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)	407,067	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	309,371	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	407,067	36.00
37.00	Subtotal (see instructions)	3,666,429	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)	3,666,429	40.00
40.01	Sequestration adjustment (see instructions)	73,329	40.01
41.00	Interim payments	4,227,889	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-634,789	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/24/2015 4:07 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	69	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	69	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	400	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)	400	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)	400	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	331	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)	69	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	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)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	69	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)	69	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	69	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	69	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	69	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
41.00	Interim payments	71	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-3	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2015 4:07 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		5,021,572		4,219,948	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	05/22/2014	193,848	09/17/2014	49,604	3.01
3.02		09/17/2014	56,340		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	05/22/2014	41,663	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)		250,188		7,941	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,271,760		4,227,889	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,024,885		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		634,789	6.02
7.00	Total Medicare program liability (see instructions)		6,296,645		3,593,100	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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2015 4:07 pm

Component CCN: 14Z317 | 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		888,139		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	05/22/2014	46,110		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	09/17/2014	68,380		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)		-22,270		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)		865,869		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		162,487		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,028,356		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: 141317	Period:	Worksheet E-1
Component CCN: 145979	From 10/01/2013 To 09/30/2014	Part I Date/Time Prepared: 2/24/2015 4:07 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		161,447		71	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)		161,447		71	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		3	6.02
7.00	Total Medicare program liability (see instructions)		161,447		68	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: 141317	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/24/2015 4:07 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	864	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,331	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	291	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,565	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	135,478,927	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	2,690,741	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	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)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141317 Component CCN: 14Z317	Period: From 10/01/2013 To 09/30/2014	Worksheet E-2 Date/Time Prepared: 2/24/2015 4:07 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)	769,183	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)	288,688	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	522	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)	1,057,871	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,057,871	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)	1,057,871	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,528	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)	1,049,343	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
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)	1,049,343	0	19.00
19.01	Sequestration adjustment (see instructions)	20,987	0	19.01
20.00	Interim payments	865,869	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	162,487	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: 141317	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part V Date/Time Prepared: 2/24/2015 4:07 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	6,730,247	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)	6,730,247	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,797,549	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 physicians' services in a teaching hospital (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)	6,797,549	19.00
20.00	Deductibles (exclude professional component)	381,472	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	6,416,077	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	6,416,077	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,936	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,071	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,936	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	6,425,148	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)	6,425,148	30.00
30.01	Sequestration adjustment (see instructions)	128,503	30.01
31.00	Interim payments	5,271,760	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	1,024,885	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VI Date/Time Prepared: 2/24/2015 4:07 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)	222,902	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)	222,902	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	58,160	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	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)	164,742	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	164,742	15.00
15.01	Sequestration adjustment (see instructions)	3,295	15.01
16.00	Interim payments	161,447	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	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 2/24/2015 4:07 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	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 physicians' services in a teaching hospital (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 line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 2/24/2015 4:07 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 physicians' services in a teaching hospital (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 line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §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: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/24/2015 4:07 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	1,128,930	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,647,462	0	0	0	4.00
5.00	Other receivable	640,212	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	629,649	0	0	0	7.00
8.00	Prepaid expenses	503,233	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,549,486	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	25,667,149	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,667,149	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,270,600	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	430,383	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,700,983	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,917,618	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,945,760	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,442,902	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,471,793	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	1,412,935	0	0	0	43.00
44.00	Other current liabilities	3,284,999	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,558,389	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,151,558	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	12,151,558	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	25,709,947	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,207,671				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)	25,207,671	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,917,618	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/24/2015 4:07 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		24,404,773		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		802,897				2.00
3.00	Total (sum of line 1 and line 2)		25,207,670		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	1		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		25,207,671		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,207,671		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	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141317 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/24/2015 4:07 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,140,206		9,140,206	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	164,088		164,088	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	3,156,174		3,156,174	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,460,468		12,460,468	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	153,642		153,642	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)	153,642		153,642	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,614,110		12,614,110	17.00
18.00	Ancillary services	31,202,128	77,320,550	108,522,678	18.00
19.00	Outpatient services	663,646	16,459,115	17,122,761	19.00
20.00	RHC - PAXTON CLINIC	0	5,000,288	5,000,288	20.00
20.01	RHC II -ONARGA CLINIC	0	674,727	674,727	20.01
20.02	RHC III - FORREST CLINIC	0	1,492,121	1,492,121	20.02
20.03	RHC IV - HOOPESTON	0	641,057	641,057	20.03
20.04	RHC V - FARMER CITY	0	581,142	581,142	20.04
20.05	RHC VI - GIBSON CITY	0	965,805	965,805	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	4,698,330	4,698,330	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	4,683,992	4,683,992	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	44,479,884	112,517,127	156,997,011	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,645,082		29.00
30.00	BAD DEBTS	3,467,315			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)		3,467,315		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		74,112,397		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141317	Period: From 10/01/2013 To 09/30/2014	Worksheet G-3 Date/Time Prepared: 2/24/2015 4:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	156,997,011	1.00
2.00	Less contractual allowances and discounts on patients' accounts	85,931,840	2.00
3.00	Net patient revenues (line 1 minus line 2)	71,065,171	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,112,397	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,047,226	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	242,013	6.00
7.00	Income from investments	208,252	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	2,873,361	24.00
24.01	GRANT INCOME	99,758	24.01
24.02	REALIZED GAIN	79,448	24.02
24.03	UNREALIZED GAIN	347,290	24.03
24.04	ROUNDING	1	24.04
25.00	Total other income (sum of lines 6-24)	3,850,123	25.00
26.00	Total (line 5 plus line 25)	802,897	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	802,897	29.00

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

Provider CCN: 141317 Component CCN: 143408 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 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	1,493,666	0	1,493,666	0	1,493,666	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	435,273	0	435,273	0	435,273	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	326,521	0	326,521	0	326,521	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	2,255,460	0	2,255,460	0	2,255,460	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	236,454	236,454	0	236,454	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	236,454	236,454	0	236,454	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,255,460	236,454	2,491,914	0	2,491,914	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	110,485	963,451	1,073,936	208,932	1,282,868	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	110,485	963,451	1,073,936	208,932	1,282,868	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,365,945	1,199,905	3,565,850	208,932	3,774,782	32.00

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

Provider CCN: 141317 | Component CCN: 143408 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 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	1,493,666		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	435,273		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	326,521		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	2,255,460		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	236,454		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	236,454		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,491,914		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	-226,760	1,056,108		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-226,760	1,056,108		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-226,760	3,548,022		32.00

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

Provider CCN: 141317 Component CCN: 143440 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 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	155,783	0	155,783	61,214	216,997	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	209,661	0	209,661	0	209,661	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	137,838	0	137,838	0	137,838	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	503,282	0	503,282	61,214	564,496	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	46,508	46,508	0	46,508	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	46,508	46,508	0	46,508	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	503,282	46,508	549,790	61,214	611,004	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	83,111	182,053	265,164	11,330	276,494	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	83,111	182,053	265,164	11,330	276,494	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	586,393	228,561	814,954	72,544	887,498	32.00

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

Provider CCN: 141317 | Component CCN: 143440 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 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	216,997		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	209,661		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	137,838		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	564,496		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	46,508		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	46,508		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	611,004		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	-3,996	272,498		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,996	272,498		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,996	883,502		32.00

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

Provider CCN: 141317 Component CCN: 148505 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	406,690	0	406,690	0	406,690	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	26,570	0	26,570	0	26,570	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	126,549	0	126,549	0	126,549	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	559,809	0	559,809	0	559,809	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	113,657	113,657	0	113,657	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	113,657	113,657	0	113,657	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	559,809	113,657	673,466	0	673,466	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	484,164	348,129	832,293	65,728	898,021	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	484,164	348,129	832,293	65,728	898,021	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,043,973	461,786	1,505,759	65,728	1,571,487	32.00

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

Provider CCN: 141317 | Component CCN: 148505 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	406,690		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	26,570		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	126,549		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	559,809		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	113,657		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	113,657		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	673,466		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	-81,815	816,206		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-81,815	816,206		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-81,815	1,489,672		32.00

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

Provider CCN: 141317 Component CCN: 148515 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) IV | 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	397,991	0	397,991	0	397,991	1.00
2.00	Physician Assistant	0	0	0	0	0	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	97,415	0	97,415	0	97,415	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	495,406	0	495,406	0	495,406	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	55,477	55,477	0	55,477	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	55,477	55,477	0	55,477	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	495,406	55,477	550,883	0	550,883	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	111,261	190,059	301,320	16,629	317,949	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	111,261	190,059	301,320	16,629	317,949	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	606,667	245,536	852,203	16,629	868,832	32.00

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

Provider CCN: 141317 | Component CCN: 148515 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	397,991		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	97,415		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	495,406		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	55,477		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	55,477		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	550,883		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	-45,591	272,358		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-45,591	272,358		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-45,591	823,241		32.00

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

Provider CCN: 141317 Component CCN: 148517 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) V

		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	186,409	0	186,409	0	186,409	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	99,494	0	99,494	0	99,494	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	76,485	0	76,485	0	76,485	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	362,388	0	362,388	0	362,388	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	37,089	37,089	0	37,089	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	37,089	37,089	0	37,089	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	362,388	37,089	399,477	0	399,477	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	37,123	159,242	196,365	40,134	236,499	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	37,123	159,242	196,365	40,134	236,499	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	399,511	196,331	595,842	40,134	635,976	32.00

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

Provider CCN: 141317 | Component CCN: 148517 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) V

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	186,409		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	99,494		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	76,485		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	362,388		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	37,089		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	37,089		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	399,477		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	-41,091	195,408		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-41,091	195,408		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-41,091	594,885		32.00

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

Provider CCN: 141317 Component CCN: 148516 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) VI

		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	436,987	0	436,987	0	436,987	1.00
2.00	Physician Assistant	0	0	0	0	0	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	436,987	0	436,987	0	436,987	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	76,783	76,783	0	76,783	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	76,783	76,783	0	76,783	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	436,987	76,783	513,770	0	513,770	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	117,067	166,259	283,326	16,745	300,071	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	117,067	166,259	283,326	16,745	300,071	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	554,054	243,042	797,096	16,745	813,841	32.00

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

Provider CCN: 141317 | Component CCN: 148516 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) VI

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	436,987		1.00
2.00	Physician Assistant	0	0		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	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	436,987		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	76,783		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	76,783		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	513,770		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	-85,136	214,935		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-85,136	214,935		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-85,136	728,705		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141317 | Component CCN: 143408 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-2 | Date/Time Prepared: 2/24/2015 4:07 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	1.95	8,216	4,200	8,190		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.06	7,486	2,100	6,426		3.00
4.00	Subtotal (sum of lines 1-3)	5.01	15,702		14,616	15,702	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	5.01	15,702			15,702	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					2,491,914	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)					2,491,914	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)					1,056,108	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,308,907	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,365,015	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					2,365,015	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,365,015	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					4,856,929	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141317 | Component CCN: 143440 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-2 | Date/Time Prepared: 2/24/2015 4:07 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	0.55	1,114	4,200	2,310		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.78	2,350	2,100	1,638		3.00
4.00	Subtotal (sum of lines 1-3)	1.33	3,464		3,948	3,948	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.33	3,464			3,948	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)					611,004	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)					611,004	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)					272,498	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					334,992	15.00
16.00	Total overhead (sum of lines 14 and 15)					607,490	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					607,490	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					607,490	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,218,494	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141317 | Component CCN: 148505 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-2 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.49	2,743	4,200	2,058		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.55	1,140	2,100	1,155		3.00
4.00	Subtotal (sum of lines 1-3)	1.04	3,883		3,213	3,883	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.04	3,883			3,883	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)					673,466	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)					673,466	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)					816,206	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					488,468	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,304,674	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,304,674	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,304,674	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,978,140	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141317 | Component CCN: 148515 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-2 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) IV | 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	1.18	2,277	4,200	4,956		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.23	455	2,100	483		3.00
4.00	Subtotal (sum of lines 1-3)	1.41	2,732		5,439	5,439	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.41	2,732			5,439	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)					550,883	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)					550,883	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)					272,358	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					273,239	15.00
16.00	Total overhead (sum of lines 14 and 15)					545,597	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					545,597	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					545,597	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,096,480	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141317 | Component CCN: 148517 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-2 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) V

		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	0.45	1,318	4,200	1,890		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.36	994	2,100	756		3.00
4.00	Subtotal (sum of lines 1-3)	0.81	2,312		2,646	2,646	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)	0.81	2,312			2,646	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)					399,477	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)					399,477	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)					195,408	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					191,163	15.00
16.00	Total overhead (sum of lines 14 and 15)					386,571	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					386,571	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					386,571	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					786,048	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141317 Component CCN: 148516

Period: From 10/01/2013 To 09/30/2014

Worksheet M-2

Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) VI

		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	0.68	3,250	4,200	2,856		1.00
2.00	Physician Assistant	0.38	77	2,100	798		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	1.06	3,327		3,654	3,654	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.06	3,327			3,654	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					513,770	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)					513,770	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)					214,935	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					298,658	15.00
16.00	Total overhead (sum of lines 14 and 15)					513,593	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					513,593	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					513,593	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,027,363	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141317 Component CCN: 143408	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 2/24/2015 4:07 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)		4,856,929	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		58,302	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,798,627	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		15,702	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)		15,702	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		305.61	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	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	305.61	305.61	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,847	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,481,292	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,481,292	16.00
16.01	Total program charges (see instructions)(from contractor's records)		816,115	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,237	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,875	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,133,598	16.04
16.05	Total program cost (see instructions)		1,139,473	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		58,419	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		150,892	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,139,473	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		42,994	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,182,467	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)		1,182,467	26.00
26.01	Sequestration adjustment (see instructions)		23,649	26.01
27.00	Interim payments		747,063	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		411,755	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: 141317 Component CCN: 143440	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 2/24/2015 4:07 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)		1,218,494	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		11,327	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,207,167	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,948	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)		3,948	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		305.77	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	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	305.77	305.77	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	419	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	128,118	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) *		128,118	16.00
16.01	Total program charges (see instructions)(from contractor's records)		80,412	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.)		98,776	16.04
16.05	Total program cost (see instructions)		98,776	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,648	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,153	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		98,776	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,796	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		100,572	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)		100,572	26.00
26.01	Sequestration adjustment (see instructions)		2,011	26.01
27.00	Interim payments		46,485	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		52,076	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: 141317 Component CCN: 148505	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 2/24/2015 4:07 pm
	Title XVIII	Rural Health Clinic (RHC) III	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,978,140	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		22,079	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,956,061	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,883	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)		3,883	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		503.75	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	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	503.75	503.75	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	614	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	309,303	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) *		309,303	16.00
16.01	Total program charges (see instructions)(from contractor's records)		101,566	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		466	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,419	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.)		241,245	16.04
16.05	Total program cost (see instructions)		242,664	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,328	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,954	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		242,664	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,274	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		253,938	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)		253,938	26.00
26.01	Sequestration adjustment (see instructions)		5,079	26.01
27.00	Interim payments		164,716	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		84,143	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: 141317 Component CCN: 148515	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 2/24/2015 4:07 pm
	Title XVIII	Rural Health Clinic (RHC) IV	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)		1,096,480	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		14,138	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,082,342	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,439	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)		5,439	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		199.00	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	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	199.00	199.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	531	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	105,669	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) *		105,669	16.00
16.01	Total program charges (see instructions)(from contractor's records)		92,780	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,138	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,296	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.)		77,933	16.04
16.05	Total program cost (see instructions)		79,229	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,957	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,937	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		79,229	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,296	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		84,525	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)		84,525	26.00
26.01	Sequestration adjustment (see instructions)		1,691	26.01
27.00	Interim payments		46,744	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		36,090	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: 141317 | Component CCN: 148517 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-3 | Date/Time Prepared: 2/24/2015 4:07 pm

Title XVIII | Rural Health Clinic (RHC) V

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		786,048	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		6,805	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		779,243	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,646	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)		2,646	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		294.50	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	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	294.50	294.50	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	493	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	145,189	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) *		145,189	16.00
16.01	Total program charges (see instructions)(from contractor's records)		76,011	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,548	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,597	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.)		102,638	16.04
16.05	Total program cost (see instructions)		113,235	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,295	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,834	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		113,235	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,095	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		115,330	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)		115,330	26.00
26.01	Sequestration adjustment (see instructions)		2,307	26.01
27.00	Interim payments		50,336	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		62,687	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: 141317 Component CCN: 148516	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 2/24/2015 4:07 pm
	Title XVIII	Rural Health Clinic (RHC) VI	

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,027,363	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		31,675	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		995,688	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,654	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,654	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		272.49	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	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	272.49	272.49	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	201	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	54,770	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) *		54,770	16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,786	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,713	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		12,304	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.)		31,781	16.04
16.05	Total program cost (see instructions)		44,085	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,740	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,467	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		44,085	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,285	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		48,370	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)		48,370	26.00
26.01	Sequestration adjustment (see instructions)		967	26.01
27.00	Interim payments		25,505	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		21,898	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317 | Component CCN: 143408 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-4 | Date/Time Prepared: 2/24/2015 4:07 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	2,255,460	2,255,460	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000404	0.001544	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	911	3,482	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	12,999	12,520	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	13,910	16,002	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	2,491,914	2,491,914	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	2,365,015	2,365,015	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005582	0.006422	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	13,202	15,188	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	27,112	31,190	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	132	505	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	205.39	61.76	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	68	470	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	13,967	29,027	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		58,302	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		42,994	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317 | Component CCN: 143440 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-4 | Date/Time Prepared: 2/24/2015 4:07 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	564,496	564,496	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000366	0.000765	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	207	432	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,299	1,742	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,506	2,174	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	611,004	611,004	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	607,490	607,490	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005738	0.003558	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,486	2,161	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	6,992	4,335	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	34	70	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	205.65	61.93	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	29	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	1,796	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		11,327	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,796	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317 | Component CCN: 148505 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-4 | Date/Time Prepared: 2/24/2015 4:07 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	559,809	559,809	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000031	0.001875	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	17	1,050	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	394	6,056	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	411	7,106	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	673,466	673,466	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	1,304,674	1,304,674	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000610	0.010551	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	796	13,766	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,207	20,872	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	4	245	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	301.75	85.19	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	8	104	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,414	8,860	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		22,079	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		11,274	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317 | Component CCN: 148515 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-4 | Date/Time Prepared: 2/24/2015 4:07 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	495,406	495,406	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000523	0.001059	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	259	525	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,185	2,134	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,444	2,659	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	550,883	550,883	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	545,597	545,597	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008067	0.004827	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,401	2,634	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,845	5,293	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	43	86	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	205.70	61.55	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	66	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,234	4,062	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		14,138	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		5,296	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317 | Component CCN: 148517 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-4 | Date/Time Prepared: 2/24/2015 4:07 pm

Title XVIII | Rural Health Clinic (RHC) V

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	362,388	362,388	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000305	0.001006	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	111	365	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,625	1,357	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,736	1,722	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	399,477	399,477	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	386,571	386,571	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004346	0.004311	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,680	1,667	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,416	3,389	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	17	55	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	200.94	61.62	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	34	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	2,095	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		6,805	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		2,095	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317 | Component CCN: 148516 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-4 | Date/Time Prepared: 2/24/2015 4:07 pm

Title XVIII | Rural Health Clinic (RHC) VI

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	436,987	436,987	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001729	0.003273	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	756	1,430	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	9,208	4,446	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	9,964	5,876	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	513,770	513,770	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	513,593	513,593	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.019394	0.011437	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	9,961	5,874	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	19,925	11,750	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	94	177	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	211.97	66.38	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	8	39	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,696	2,589	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		31,675	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		4,285	16.00

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

Provider CCN: 141317 Component CCN: 143408 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-5 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		812,704	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		05/22/2014	50,889	3.50
3.51		09/14/2014	14,752	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)		-65,641	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		747,063	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		411,755	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,158,818	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: 141317 Component CCN: 143440

Period: From 10/01/2013 To 09/30/2014

Worksheet M-5

Date/Time Prepared: 2/24/2015 4:07 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		45,749	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		05/22/2014	736	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)		736	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		46,485	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		52,076	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		98,561	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: 141317 Component CCN: 148505 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-5 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		146,837	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		05/22/2014	9,442	3.01
3.02		09/17/2014	8,437	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)		17,879	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		164,716	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		84,143	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		248,859	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: 141317 Component CCN: 148515 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-5 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) IV | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		81,309	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		05/22/2014	22,671	3.50
3.51		09/17/2014	11,894	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-34,565	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		46,744	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		36,090	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		82,834	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: 141317 Component CCN: 148517 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-5 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) V

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		55,184	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		05/22/2014	3,760	3.50
3.51		09/17/2014	1,088	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)		-4,848	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		50,336	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		62,687	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		113,023	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: 141317 Component CCN: 148516 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-5 | Date/Time Prepared: 2/24/2015 4:07 pm

Rural Health Clinic (RHC) VI

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		28,811	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		05/22/2014	3,306	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)		-3,306	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		25,505	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		21,898	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		47,403	7.00

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