This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141346	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/15/2015 3:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/15/2015 Time: 3:26 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 FAYETTE COUNTY HOSPITAL (141346) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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	337,216	-89,086	764,878	1,917,930	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	143,720	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	5,964	0		0	7.00
10.00	RURAL HEALTH CLINIC (RHC) VANDALIA I	0		329		0	10.00
10.01	RURAL HEALTH CLINIC (RHC) ST ELMO II	0		116		0	10.01
200.00	Total	0	486,900	-88,641	764,878	1,917,930	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/15/2015 3:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SEVENTH & TAYLOR	PO Box:			1.00
2.00	City: VANDALIA	State: IL	Zip Code: 62471-	County: FAYETTE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FAYETTE COUNTY HOSPITAL	141346	14999	1	04/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FAYETTE COUNTY SNF	14Z346	14999		04/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAYETTE COUNTY SNF	145499	14999		07/01/1983	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CONFIDENCE MEDICAL - VANDALIA	148527	14999		06/01/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CONFIDENCE MEDICAL - ST ELMO	148528	14999		06/01/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	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)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period 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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 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 column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/15/2015 3:25 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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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 Wkst. D, Parts III & IV and D-2, Pt. 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, § 2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/15/2015 3:25 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 Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/15/2015 3:25 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 nonprovider 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. (see 42 CFR 412.424(d)(1)(iii)(c)) 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, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/15/2015 3:25 pm

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. 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	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		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 column 1 is 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 hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/15/2015 3:25 pm

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	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 the 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, § 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 (see instructions)						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)	880,614	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141346	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/15/2015 3:25 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2014	12/31/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/15/2015 3:25 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/06/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/15/2015 3:25 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/15/2015 3:25 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/06/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/15/2015 3:25 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	37,728.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	37,728.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	3,120.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	40,848.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	85	31,025		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC) VANDALIA	88.00				0	26.00
26.01	RURAL HEALTH CLINIC (RHC) ST ELMO	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		110				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/15/2015 3:25 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)	978	219	1,572			1.00
2.00	HMO and other (see instructions)	92	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,104	0	1,104			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		105	105			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,082	324	2,781			7.00
8.00	INTENSIVE CARE UNIT	96	0	130			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,178	324	2,911	0.00	154.50	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	154	9,647	20,597	0.00	37.39	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC) VANDALIA	5	0	2,438	0.00	4.94	26.00
26.01	RURAL HEALTH CLINIC (RHC) ST ELMO	2	0	1,454	0.00	1.75	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	198.58	27.00
28.00	Observation Bed Days		0	619			28.00
29.00	Ambulance Trips	377					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/15/2015 3:25 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	350	89	570	1.00
2.00	HMO and other (see instructions)			26	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	350	89	570	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC) VANDALIA	0.00					26.00
26.01	RURAL HEALTH CLINIC (RHC) ST ELMO	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/15/2015 3:25 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	72,711	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,054,382	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	54,655	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	7,987	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	37,373	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	221,878	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	623,584	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	93,419	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	14,351	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,180,340	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/15/2015 3:25 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	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	2	0	2	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	19	0	19	16.00
17.00		RVA	28	0	28	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	26	0	26	19.00
20.00		RHA	9	0	9	20.00
21.00		RMC	7	0	7	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	27	0	27	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	8	0	8	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	7	0	7	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	6	0	6	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	4	0	4	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	5	0	5	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	6	0	6	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: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/15/2015 3:25 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	0	0	0	199.00
200.00	TOTAL		154	0	154	200.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	44,399			207.00

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

Provider CCN: 141346 Component CCN: 148527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 Date/Time Prepared: 5/15/2015 3:25 pm

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

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

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

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

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

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

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

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

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

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

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

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

Provider CCN: 141346
Component CCN: 148527

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-8
Date/Time Prepared:
5/15/2015 3:25 pm

Rural Health Clinic (RHC) I

Cost

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

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

Provider CCN: 141346 Component CCN: 148528 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 Date/Time Prepared: 5/15/2015 3:25 pm

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141346 Component CCN: 148528	Period: From 01/01/2014 To 12/31/2014	Worksheet S-8 Date/Time Prepared: 5/15/2015 3:25 pm
		Rural Health Clinic (RHC) II	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/15/2015 3:25 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)	0.342353	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,144,615	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	1,698,663	5.00
6.00	Medicaid charges	15,615,217	6.00
7.00	Medicaid cost (line 1 times line 6)	5,345,916	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,502,638	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,502,638	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	100,334	0	100,334	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	34,350	0	34,350	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)	34,350	0	34,350	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)	3,365,561	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	634,577	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,730,984	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	934,961	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	969,311	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,471,949	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,499,555	1,499,555	-403,362	1,096,193	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	449,125	449,125	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	75,921	2,682,292	2,758,213	11,852	2,770,065	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	481,047	2,394,306	2,875,353	48,241	2,923,594	5.00
7.00	00700	OPERATION OF PLANT	241,411	58,404	299,815	18,296	318,111	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	577,008	577,008	0	577,008	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	11,507	11,507	0	11,507	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	77,262	43,751	121,013	0	121,013	8.00
9.00	00900	HOUSEKEEPING	391,732	104,178	495,910	0	495,910	9.00
10.00	01000	DIETARY	311,651	397,698	709,349	-122,670	586,679	10.00
11.00	01100	CAFETERIA	0	0	0	122,670	122,670	11.00
13.00	01300	NURSING ADMINISTRATION	270,725	25,274	295,999	0	295,999	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,395	89,972	140,367	0	140,367	14.00
15.00	01500	PHARMACY	193,088	138,972	332,060	0	332,060	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	269,681	108,954	378,635	0	378,635	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	276,625	276,625	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,290,320	265,105	1,555,425	-16,732	1,538,693	30.00
31.00	03100	INTENSIVE CARE UNIT	227,455	12,044	239,499	6,917	246,416	31.00
44.00	04400	SKILLED NURSING FACILITY	1,402,841	474,634	1,877,475	-85,381	1,792,094	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	486,500	367,871	854,371	-228,127	626,244	50.00
53.00	05300	ANESTHESIOLOGY	0	283,131	283,131	-280,672	2,459	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	406,129	793,898	1,200,027	-24,642	1,175,385	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	164,608	164,608	-2,606	162,002	55.00
60.00	06000	LABORATORY	499,639	718,865	1,218,504	-42,801	1,175,703	60.00
65.00	06500	RESPIRATORY THERAPY	176,045	109,526	285,571	-29,311	256,260	65.00
66.00	06600	PHYSICAL THERAPY	395,376	43,403	438,779	-344	438,435	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,542	4,489	67,031	-54	66,977	67.00
68.00	06800	SPEECH PATHOLOGY	28,880	4,893	33,773	-397	33,376	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	341,776	341,776	363,572	705,348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	56,376	56,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	688,940	688,940	32,610	721,550	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	343,889	100,165	444,054	-614	443,440	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	111,924	28,127	140,051	-1,004	139,047	88.01
90.00	09000	CLINIC	0	596,174	596,174	-979	595,195	90.00
90.01	09002	WOUND CARE	0	119,425	119,425	0	119,425	90.01
91.00	09100	EMERGENCY	501,759	1,448,778	1,950,537	315,184	2,265,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	392,604	79,032	471,636	-330,795	140,841	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,688,816	14,776,755	23,465,571	130,977	23,596,548	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,297,416	656,195	1,953,611	-17,784	1,935,827	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	112,299	112,299	-113,193	-894	192.01
192.02	19202	PUBLIC RELATIONS	0	28,021	28,021	0	28,021	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		TOTAL (SUM OF LINES 118-199)	9,986,232	15,573,270	25,559,502	0	25,559,502	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-308,479	787,714		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	449,125		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,806	2,768,259		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,844	2,909,750		5.00
7.00	00700	OPERATION OF PLANT	-1,752	316,359		7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	577,008		7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	11,507		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,013		8.00
9.00	00900	HOUSEKEEPING	0	495,910		9.00
10.00	01000	DIETARY	-62,143	524,536		10.00
11.00	01100	CAFETERIA	0	122,670		11.00
13.00	01300	NURSING ADMINISTRATION	0	295,999		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	140,367		14.00
15.00	01500	PHARMACY	0	332,060		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,432	368,203		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-276,625	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-548,390	990,303		30.00
31.00	03100	INTENSIVE CARE UNIT	0	246,416		31.00
44.00	04400	SKILLED NURSING FACILITY	-164,335	1,627,759		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	626,244		50.00
53.00	05300	ANESTHESIOLOGY	0	2,459		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,188	1,174,197		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	162,002		55.00
60.00	06000	LABORATORY	0	1,175,703		60.00
65.00	06500	RESPIRATORY THERAPY	0	256,260		65.00
66.00	06600	PHYSICAL THERAPY	0	438,435		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	66,977		67.00
68.00	06800	SPEECH PATHOLOGY	0	33,376		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	705,348		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	56,376		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	721,550		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	443,440		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	-2,436	136,611		88.01
90.00	09000	CLINIC	0	595,195		90.00
90.01	09002	WOUND CARE	0	119,425		90.01
91.00	09100	EMERGENCY	-989,911	1,275,810		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	140,841		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,381,341	21,215,207		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-2,003	1,933,824		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	-894		192.01
192.02	19202	PUBLIC RELATIONS	0	28,021		192.02
192.03	19203	PERSONAL LAUNDRY	0	0		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0		192.04
200.00		TOTAL (SUM OF LINES 118-199)	-2,383,344	23,176,158		200.00

RECLASSIFICATIONS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/15/2015 3:25 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	53,895	68,775		1.00
	TOTALS		53,895	68,775		
	B - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	276,625		1.00
	TOTALS		0	276,625		
	D - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	449,125		1.00
	TOTALS		0	449,125		
	E - ER					
1.00	EMERGENCY	91.00	327,449	0		1.00
	TOTALS		327,449	0		
	F - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,748		1.00
	TOTALS		0	12,748		
	G - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,707		1.00
	TOTALS		0	17,707		
	H - EMPLOYEE OCC HEALTH PROCEDURES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	9,590	2,262		1.00
	TOTALS		9,590	2,262		
	I - WELLNESS DEPR AND UTILITIES					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	76,218		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	17,786		2.00
3.00	OPERATION OF PLANT	7.00	0	18,296		3.00
	TOTALS		0	112,300		
	J - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	363,572		1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	56,376		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	7,120		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	TOTALS		0	427,068		
	K - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	32,610		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	32,610		
500.00	Grand Total: Increases		390,934	1,399,220		500.00

RECLASSIFICATIONS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/15/2015 3:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	53,895	68,775	0		1.00
	TOTALS		53,895	68,775			
	B - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	276,625	0		1.00
	TOTALS		0	276,625			
	D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	449,125	9		1.00
	TOTALS		0	449,125			
	E - ER						
1.00	AMBULANCE SERVICES	95.00	327,449	0	0		1.00
	TOTALS		327,449	0			
	F - INTEREST						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	12,748	9		1.00
	TOTALS		0	12,748			
	G - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	17,707	9		1.00
	TOTALS		0	17,707			
	H - EMPLOYEE OCC HEALTH PROCEDURES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	9,590	2,262	0		1.00
	TOTALS		9,590	2,262			
	I - WELLNESS DEPR AND UTILITIES						
1.00	FAYETTE COUNTY ANNEX	192.01	0	112,300	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	112,300			
	J - MED SUPPLY						
1.00	ADULTS & PEDIATRICS	30.00	0	12,287	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	71,876	0		2.00
3.00	OPERATING ROOM	50.00	0	224,167	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	4,045	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	24,367	0		5.00
7.00	LABORATORY	60.00	0	42,801	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	29,282	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	327	0		9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	54	0		10.00
11.00	SPEECH PATHOLOGY	68.00	0	397	0		11.00
12.00	RURAL HEALTH CLINIC (RHC) VANDALIA	88.00	0	614	0		12.00
13.00	RURAL HEALTH CLINIC (RHC) ST ELMO	88.01	0	992	0		13.00
14.00	CLINIC	90.00	0	911	0		14.00
15.00	EMERGENCY	91.00	0	9,409	0		15.00
16.00	AMBULANCE SERVICES	95.00	0	851	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,795	0		17.00
18.00	FAYETTE COUNTY ANNEX	192.01	0	893	0		18.00
	TOTALS		0	427,068			
	K - PHARMACY						
1.00	ADULTS & PEDIATRICS	30.00	0	4,445	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	203	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	13,505	0		3.00
4.00	OPERATING ROOM	50.00	0	3,960	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	2	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	275	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,606	0		7.00
9.00	RESPIRATORY THERAPY	65.00	0	29	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	17	0		10.00
11.00	RURAL HEALTH CLINIC (RHC) ST ELMO	88.01	0	12	0		11.00
12.00	CLINIC	90.00	0	68	0		12.00
13.00	EMERGENCY	91.00	0	2,856	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	2,495	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,137	0		15.00
	TOTALS		0	32,610			
500.00	Grand Total: Decreases		390,934	1,399,220			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/15/2015 3:25 pm

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/15/2015 3:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,499,555	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,499,555	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,499,555	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,499,555	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/15/2015 3:25 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	27,359,543	0	27,359,543	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	27,359,543	0	27,359,543	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	787,714	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	449,125	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,236,839	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	787,714	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	449,125	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,236,839	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/15/2015 3:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-12,748	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,248	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,538,301			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	209			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-62,143	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,432	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,752	OPERATION OF PLANT	7.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-276,625	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-295,731	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/15/2015 3:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00			0		0.00	0	33.00
33.01			0		0.00	0	33.01
33.02			0		0.00	0	33.02
33.03	AHA/IHA	A	-11,596	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	EMPLOYEE BENEFIT OTHER REVENUE	A	-1,806	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.07			0		0.00	0	33.07
34.00			0		0.00	0	34.00
35.00	RADIOLOGY OTHER	A	-1,397	RADIOLOGY-DIAGNOSTIC	54.00	0	35.00
36.00	LTC ASSESSMENT	A	-164,335	SKILLED NURSING FACILITY	44.00	0	36.00
37.00	BAD DEBT EXPENSE	A	-2,436	RURAL HEALTH CLINIC (RHC) ST ELMO	88.01	0	37.00
38.00	BAD DEBT EXPENSE	A	-2,003	PHYSICIANS' PRIVATE OFFICES	192.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,383,344				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/15/2015 3:25 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ALLIANT MANAGEMENT	693,894	693,894	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	BLUE GRASS LEASING	67,749	67,749	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ALLIANT PURCHASING	7,020	7,020	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	MAGELLAN MANAGEMENT	10,092	10,092	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	BLUE	93,829	93,829	4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	160,518	160,309	4.01
5.00	0		0	1,033,102	1,032,893	5.00

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

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

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

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

6.00	B	ALLIANT MGT	100.00		0.00	6.00
7.00	B	BLUEGRASS LEAS	100.00		0.00	7.00
8.00	B	ALLIANT PURCH	100.00		0.00	8.00
9.00	B	MAGELLAN MANAGE	100.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141346	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/15/2015 3:25 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
4.00	0	0		4.00
4.01	209	0		4.01
5.00	209			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/15/2015 3:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,365,333	989,911	375,422	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	548,390	548,390	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,913,723	1,538,301	375,422		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	989,911		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	548,390		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,538,301		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	787,714	787,714				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	449,125		449,125			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,768,259	7,051	401	2,775,711		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,909,750	73,211	273,191	134,863	3,391,015	5.00
7.00	00700	OPERATION OF PLANT	316,359	97,998	11,994	67,681	494,032	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	577,008	0	0	0	577,008	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	11,507	0	0	0	11,507	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	121,013	18,066	351	21,661	161,091	8.00
9.00	00900	HOUSEKEEPING	495,910	3,275	0	109,824	609,009	9.00
10.00	01000	DIETARY	524,536	9,761	2,176	72,263	608,736	10.00
11.00	01100	CAFETERIA	122,670	16,515	0	15,110	154,295	11.00
13.00	01300	NURSING ADMINISTRATION	295,999	4,097	0	75,899	375,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	140,367	4,661	0	14,128	159,156	14.00
15.00	01500	PHARMACY	332,060	7,756	7,630	54,133	401,579	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	368,203	27,686	1,857	75,606	473,352	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	990,303	68,259	4,955	361,746	1,425,263	30.00
31.00	03100	INTENSIVE CARE UNIT	246,416	8,022	0	63,768	318,206	31.00
44.00	04400	SKILLED NURSING FACILITY	1,627,759	146,994	2,781	393,296	2,170,830	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	626,244	44,639	10,668	136,392	817,943	50.00
53.00	05300	ANESTHESIOLOGY	2,459	0	0	0	2,459	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,174,197	35,223	71,445	113,860	1,394,725	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	162,002	0	0	0	162,002	55.00
60.00	06000	LABORATORY	1,175,703	13,968	6,847	140,076	1,336,594	60.00
65.00	06500	RESPIRATORY THERAPY	256,260	23,283	14,355	49,355	343,253	65.00
66.00	06600	PHYSICAL THERAPY	438,435	30,326	2,671	110,845	582,277	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,977	2,131	843	17,534	87,485	67.00
68.00	06800	SPEECH PATHOLOGY	33,376	1,473	0	8,097	42,946	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	705,348	0	0	0	705,348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	56,376	0	0	0	56,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	721,550	0	0	0	721,550	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	443,440	0	0	96,411	539,851	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	136,611	0	0	31,378	167,989	88.01
90.00	09000	CLINIC	595,195	41,701	0	0	636,896	90.00
90.01	09002	WOUND CARE	119,425	0	0	0	119,425	90.01
91.00	09100	EMERGENCY	1,275,810	28,752	226	232,472	1,537,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	140,841	8,281	7,995	18,266	175,383	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,215,207	723,129	420,386	2,414,664	20,760,836	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,815	0	0	3,815	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,933,824	52,333	22,581	361,047	2,369,785	192.00
192.01	19201	FAYETTE COUNTY ANNEX	-894	8,437	6,158	0	13,701	192.01
192.02	19202	PUBLIC RELATIONS	28,021	0	0	0	28,021	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,176,158	787,714	449,125	2,775,711	23,176,158	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,391,015					5.00
7.00	00700	OPERATION OF PLANT	84,673	578,705				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	98,895	0	675,903			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	1,972	0	0	13,479		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	27,610	17,390	21,507	0	227,598	8.00
9.00	00900	HOUSEKEEPING	104,379	3,152	3,898	0	13,143	9.00
10.00	01000	DIETARY	104,332	9,397	11,621	0	2,382	10.00
11.00	01100	CAFETERIA	26,445	15,897	19,660	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	64,443	3,944	4,878	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,278	4,487	5,549	0	0	14.00
15.00	01500	PHARMACY	68,827	7,466	9,233	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	81,129	26,651	32,960	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	244,279	65,708	81,262	0	48,282	30.00
31.00	03100	INTENSIVE CARE UNIT	54,538	7,722	9,550	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	372,063	141,501	174,996	0	113,680	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	140,189	42,971	53,143	0	8,248	50.00
53.00	05300	ANESTHESIOLOGY	421	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,045	33,906	41,932	0	4,841	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,766	0	0	0	0	55.00
60.00	06000	LABORATORY	229,082	13,446	16,629	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	58,831	22,413	27,718	0	0	65.00
66.00	06600	PHYSICAL THERAPY	99,798	29,193	36,103	0	9,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,994	2,051	2,537	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,361	1,418	1,753	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,891	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,662	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,668	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	92,526	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	28,792	0	0	0	0	88.01
90.00	09000	CLINIC	109,159	40,143	0	13,479	0	90.00
90.01	09002	WOUND CARE	20,468	0	0	0	0	90.01
91.00	09100	EMERGENCY	263,474	27,677	34,228	0	14,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	30,059	0	9,858	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,977,049	516,533	599,015	13,479	214,709	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	3,673	4,542	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	406,161	50,377	62,301	0	87	192.00
192.01	19201	FAYETTE COUNTY ANNEX	2,348	8,122	10,045	0	660	192.01
192.02	19202	PUBLIC RELATIONS	4,803	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	12,142	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,391,015	578,705	675,903	13,479	227,598	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	733,581					9.00
10.00	01000	DIETARY	12,176	748,644				10.00
11.00	01100	CAFETERIA	20,599	0	236,896			11.00
13.00	01300	NURSING ADMINISTRATION	5,111	0	11,261	465,632		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,814	0	3,695	0	205,979	14.00
15.00	01500	PHARMACY	9,674	0	4,540	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,534	0	10,012	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,143	93,477	30,072	155,302	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,006	3,351	6,599	34,077	0	31.00
44.00	04400	SKILLED NURSING FACILITY	183,353	616,521	65,791	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,681	0	11,437	59,067	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,935	0	14,341	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	17,423	0	19,092	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	29,042	0	6,247	0	0	65.00
66.00	06600	PHYSICAL THERAPY	37,827	0	9,590	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,658	0	1,091	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,837	0	633	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	190,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	15,245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0	44,891	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	15,903	0	88.01
90.00	09000	CLINIC	52,016	35,295	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	35,863	0	27,591	142,488	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,329	0	2,692	13,904	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	653,021	748,644	224,684	465,632	205,979	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,759	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65,277	0	12,212	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	10,524	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	733,581	748,644	236,896	465,632	205,979	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	501,319					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	658,638				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	40,618	0	2,269,406	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,205	0	446,254	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	38,194	0	3,876,929	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,467	0	1,212,146	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,880	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	136,459	0	1,909,184	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,800	0	197,568	0	55.00
60.00	06000	LABORATORY	0	130,086	0	1,762,352	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,977	0	510,481	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,632	0	820,689	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,216	0	113,032	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	653	0	56,601	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,727	0	1,047,700	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	639	0	81,922	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	501,319	63,130	0	1,409,667	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	1,378	0	678,646	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	2,479	0	215,163	0	88.01
90.00	09000	CLINIC	0	20,797	0	907,785	0	90.00
90.01	09002	WOUND CARE	0	3,891	0	143,784	0	90.01
91.00	09100	EMERGENCY	0	73,184	0	2,156,629	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	13,499	0	255,724	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	501,319	631,031	0	20,074,542	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	17,443	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,607	0	2,993,807	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	45,400	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	32,824	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	12,142	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	501,319	658,638	0	23,176,158	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,269,406		30.00
31.00	03100	INTENSIVE CARE UNIT	446,254		31.00
44.00	04400	SKILLED NURSING FACILITY	3,876,929		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,212,146		50.00
53.00	05300	ANESTHESIOLOGY	2,880		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,909,184		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	197,568		55.00
60.00	06000	LABORATORY	1,762,352		60.00
65.00	06500	RESPIRATORY THERAPY	510,481		65.00
66.00	06600	PHYSICAL THERAPY	820,689		66.00
67.00	06700	OCCUPATIONAL THERAPY	113,032		67.00
68.00	06800	SPEECH PATHOLOGY	56,601		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,047,700		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	81,922		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,409,667		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	678,646		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	215,163		88.01
90.00	09000	CLINIC	907,785		90.00
90.01	09002	WOUND CARE	143,784		90.01
91.00	09100	EMERGENCY	2,156,629		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	255,724		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,074,542		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,443		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,993,807		192.00
192.01	19201	FAYETTE COUNTY ANNEX	45,400		192.01
192.02	19202	PUBLIC RELATIONS	32,824		192.02
192.03	19203	PERSONAL LAUNDRY	12,142		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0		192.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	23,176,158		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,051	401	7,452	7,452	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	73,211	273,191	346,402	362	5.00
7.00	00700	OPERATION OF PLANT	0	97,998	11,994	109,992	182	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,066	351	18,417	58	8.00
9.00	00900	HOUSEKEEPING	0	3,275	0	3,275	295	9.00
10.00	01000	DIETARY	0	9,761	2,176	11,937	194	10.00
11.00	01100	CAFETERIA	0	16,515	0	16,515	41	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,097	0	4,097	204	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,661	0	4,661	38	14.00
15.00	01500	PHARMACY	0	7,756	7,630	15,386	145	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,686	1,857	29,543	203	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	68,259	4,955	73,214	972	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,022	0	8,022	171	31.00
44.00	04400	SKILLED NURSING FACILITY	0	146,994	2,781	149,775	1,053	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,639	10,668	55,307	366	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,223	71,445	106,668	306	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	13,968	6,847	20,815	376	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,283	14,355	37,638	133	65.00
66.00	06600	PHYSICAL THERAPY	0	30,326	2,671	32,997	298	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,131	843	2,974	47	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,473	0	1,473	22	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0	0	259	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	84	88.01
90.00	09000	CLINIC	0	41,701	0	41,701	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	28,752	226	28,978	624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,281	7,995	16,276	49	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	723,129	420,386	1,143,515	6,482	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,815	0	3,815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	52,333	22,581	74,914	970	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	8,437	6,158	14,595	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	787,714	449,125	1,236,839	7,452	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	346,764					5.00
7.00	00700	OPERATION OF PLANT	8,658	118,832				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	10,113	0	10,113			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	202	0	0	202		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,823	3,571	322	0	25,191	8.00
9.00	00900	HOUSEKEEPING	10,673	647	58	0	1,455	9.00
10.00	01000	DIETARY	10,669	1,930	174	0	264	10.00
11.00	01100	CAFETERIA	2,704	3,264	294	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,590	810	73	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,789	921	83	0	0	14.00
15.00	01500	PHARMACY	7,038	1,533	138	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,296	5,473	493	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,979	13,493	1,216	0	5,344	30.00
31.00	03100	INTENSIVE CARE UNIT	5,577	1,586	143	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	38,046	29,057	2,620	0	12,581	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,335	8,824	795	0	913	50.00
53.00	05300	ANESTHESIOLOGY	43	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,444	6,962	627	0	536	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,839	0	0	0	0	55.00
60.00	06000	LABORATORY	23,425	2,761	249	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,016	4,602	415	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,205	5,994	540	0	1,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,533	421	38	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	753	291	26	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,362	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	988	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,646	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	9,461	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	2,944	0	0	0	0	88.01
90.00	09000	CLINIC	11,162	8,243	0	202	0	90.00
90.01	09002	WOUND CARE	2,093	0	0	0	0	90.01
91.00	09100	EMERGENCY	26,942	5,683	512	0	1,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,074	0	147	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	304,422	106,066	8,963	202	23,764	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	67	754	68	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,544	10,344	932	0	10	192.00
192.01	19201	FAYETTE COUNTY ANNEX	240	1,668	150	0	73	192.01
192.02	19202	PUBLIC RELATIONS	491	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	1,344	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	346,764	118,832	10,113	202	25,191	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	16,403					9.00
10.00	01000	DIETARY	272	25,440				10.00
11.00	01100	CAFETERIA	461	0	23,279			11.00
13.00	01300	NURSING ADMINISTRATION	114	0	1,107	12,995		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	130	0	363	0	8,985	14.00
15.00	01500	PHARMACY	216	0	446	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	772	0	984	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,904	3,176	2,955	4,334	0	30.00
31.00	03100	INTENSIVE CARE UNIT	224	114	648	951	0	31.00
44.00	04400	SKILLED NURSING FACILITY	4,101	20,951	6,466	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,245	0	1,124	1,648	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	982	0	1,409	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	390	0	1,876	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	649	0	614	0	0	65.00
66.00	06600	PHYSICAL THERAPY	846	0	942	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	59	0	107	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	41	0	62	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0	1,253	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	444	0	88.01
90.00	09000	CLINIC	1,163	1,199	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	802	0	2,711	3,977	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	231	0	265	388	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,602	25,440	22,079	12,995	8,985	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	106	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,460	0	1,200	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	235	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,403	25,440	23,279	12,995	8,985	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	24,902					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,764				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,823		134,410	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	153		17,589	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	2,655		267,305	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,631		86,188	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		43	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,472		151,406	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	542		3,381	0	55.00
60.00	06000	LABORATORY	0	9,041		58,933	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,597		51,664	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,156		54,004	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	154		5,333	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	45		2,713	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,136		22,818	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	44		1,697	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,902	4,388		41,936	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	96		11,069	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	172		3,644	0	88.01
90.00	09000	CLINIC	0	1,445		65,115	0	90.00
90.01	09002	WOUND CARE	0	270		2,363	0	90.01
91.00	09100	EMERGENCY	0	5,087		76,961	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	938		21,368	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,902	43,845	0	1,079,940	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		4,810	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,919		133,293	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		16,961	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0		491	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0		1,344	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0		0	0	192.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,902	45,764	0	1,236,839	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	134,410		30.00
31.00	03100	INTENSIVE CARE UNIT	17,589		31.00
44.00	04400	SKILLED NURSING FACILITY	267,305		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	86,188		50.00
53.00	05300	ANESTHESIOLOGY	43		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,406		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,381		55.00
60.00	06000	LABORATORY	58,933		60.00
65.00	06500	RESPIRATORY THERAPY	51,664		65.00
66.00	06600	PHYSICAL THERAPY	54,004		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,333		67.00
68.00	06800	SPEECH PATHOLOGY	2,713		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,818		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,697		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,936		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	11,069		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	3,644		88.01
90.00	09000	CLINIC	65,115		90.00
90.01	09002	WOUND CARE	2,363		90.01
91.00	09100	EMERGENCY	76,961		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	21,368		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,079,940		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,810		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	133,293		192.00
192.01	19201	FAYETTE COUNTY ANNEX	16,961		192.01
192.02	19202	PUBLIC RELATIONS	491		192.02
192.03	19203	PERSONAL LAUNDRY	1,344		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0		192.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,236,839		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	100,548					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		567,416				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	900	507	9,900,721			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,345	345,144	481,047	-3,391,015	19,785,143	5.00
7.00	00700	OPERATION OF PLANT	12,509	15,153	241,411	0	494,032	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	577,008	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	11,507	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	444	77,262	0	161,091	8.00
9.00	00900	HOUSEKEEPING	418	0	391,732	0	609,009	9.00
10.00	01000	DIETARY	1,246	2,749	257,756	0	608,736	10.00
11.00	01100	CAFETERIA	2,108	0	53,895	0	154,295	11.00
13.00	01300	NURSING ADMINISTRATION	523	0	270,725	0	375,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	0	50,395	0	159,156	14.00
15.00	01500	PHARMACY	990	9,639	193,088	0	401,579	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,534	2,346	269,681	0	473,352	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,713	6,260	1,290,320	0	1,425,263	30.00
31.00	03100	INTENSIVE CARE UNIT	1,024	0	227,455	0	318,206	31.00
44.00	04400	SKILLED NURSING FACILITY	18,763	3,513	1,402,841	0	2,170,830	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,698	13,478	486,500	0	817,943	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,459	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,496	90,262	406,129	0	1,394,725	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	162,002	55.00
60.00	06000	LABORATORY	1,783	8,650	499,639	0	1,336,594	60.00
65.00	06500	RESPIRATORY THERAPY	2,972	18,136	176,045	0	343,253	65.00
66.00	06600	PHYSICAL THERAPY	3,871	3,374	395,376	0	582,277	66.00
67.00	06700	OCCUPATIONAL THERAPY	272	1,065	62,542	0	87,485	67.00
68.00	06800	SPEECH PATHOLOGY	188	0	28,880	0	42,946	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	705,348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	56,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	721,550	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	343,889	0	539,851	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	111,924	0	167,989	88.01
90.00	09000	CLINIC	5,323	0	0	0	636,896	90.00
90.01	09002	WOUND CARE	0	0	0	0	119,425	90.01
91.00	09100	EMERGENCY	3,670	286	829,208	0	1,537,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,057	10,101	65,155	0	175,383	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,304	531,107	8,612,895	-3,391,015	17,369,821	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	487	0	0	0	3,815	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,680	28,529	1,287,826	0	2,369,785	192.00
192.01	19201	FAYETTE COUNTY ANNEX	1,077	7,780	0	0	13,701	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	28,021	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	787,714	449,125	2,775,711		3,391,015	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.834209	0.791527	0.280354		0.171392	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,452		346,764	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000753		0.017526	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	OPERATION OF PLANT (SQ FT)	OPERATION OF PLANT HOSP ONLY (SQ FT)	OPERATION OF PLANT ANNEX ONLY (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			7.00	7.01	7.02	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	76,737					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	72,471				7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	5,323			7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,306	0	433,472		8.00
9.00	00900	HOUSEKEEPING	418	418	0	25,032	75,070	9.00
10.00	01000	DIETARY	1,246	1,246	0	4,536	1,246	10.00
11.00	01100	CAFETERIA	2,108	2,108	0	0	2,108	11.00
13.00	01300	NURSING ADMINISTRATION	523	523	0	0	523	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	595	0	0	595	14.00
15.00	01500	PHARMACY	990	990	0	0	990	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,534	3,534	0	0	3,534	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,713	8,713	0	91,955	8,713	30.00
31.00	03100	INTENSIVE CARE UNIT	1,024	1,024	0	0	1,024	31.00
44.00	04400	SKILLED NURSING FACILITY	18,763	18,763	0	216,510	18,763	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,698	5,698	0	15,709	5,698	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,496	4,496	0	9,220	4,496	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,783	1,783	0	0	1,783	60.00
65.00	06500	RESPIRATORY THERAPY	2,972	2,972	0	0	2,972	65.00
66.00	06600	PHYSICAL THERAPY	3,871	3,871	0	17,653	3,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	272	272	0	0	272	67.00
68.00	06800	SPEECH PATHOLOGY	188	188	0	0	188	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	0	88.01
90.00	09000	CLINIC	5,323	0	5,323	0	5,323	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,670	3,670	0	28,310	3,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,057	0	0	1,057	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,493	64,227	5,323	408,925	66,826	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	487	487	0	0	487	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,680	6,680	0	165	6,680	192.00
192.01	19201	FAYETTE COUNTY ANNEX	1,077	1,077	0	1,257	1,077	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	23,125	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	578,705	675,903	13,479	227,598	733,581	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.541408	9.326531	2.532219	0.525058	9.771960	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	118,832	10,113	202	25,191	16,403	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.548562	0.139545	0.037949	0.058114	0.218503	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATION (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	73,497					10.00
11.00	01100	CAFETERIA	0	13,463				11.00
13.00	01300	NURSING ADMINISTRATION	0	640	5,124			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	210	0	761,725		14.00
15.00	01500	PHARMACY	0	258	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	569	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,177	1,709	1,709	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	329	375	375	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	60,526	3,739	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	650	650	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	815	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	1,085	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	355	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	545	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	62	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	36	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	705,349	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	56,376	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	494	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	175	0	0	88.01
90.00	09000	CLINIC	3,465	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	1,568	1,568	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	153	153	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,497	12,769	5,124	761,725	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	694	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	748,644	236,896	465,632	205,979	501,319	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.186048	17.596078	90.872756	0.270411	5,013.190000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,440	23,279	12,995	8,985	24,902	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.346137	1.729109	2.536105	0.011796	249.020000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/15/2015 3:25 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY				7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,202,211			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,774,176			30.00
31.00	03100	INTENSIVE CARE UNIT	204,884			31.00
44.00	04400	SKILLED NURSING FACILITY	3,548,999			44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,180,519	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,681,392	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	724,814	0		55.00
60.00	06000	LABORATORY	12,087,527	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,135,057	0		65.00
66.00	06600	PHYSICAL THERAPY	1,545,405	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	205,939	0		67.00
68.00	06800	SPEECH PATHOLOGY	60,645	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,855,158	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	59,411	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,866,027	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	128,000	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	230,340	0		88.01
90.00	09000	CLINIC	1,932,470	0		90.00
90.01	09002	WOUND CARE	361,582	0		90.01
91.00	09100	EMERGENCY	6,800,240	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,254,357	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,636,942	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,565,269	0		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		192.01
192.02	19202	PUBLIC RELATIONS	0	0		192.02
192.03	19203	PERSONAL LAUNDRY	0	0		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0		192.04
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	658,638	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010762	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,764	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000748	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,269,406		2,269,406	0	2,269,406	30.00
31.00	03100	INTENSIVE CARE UNIT	446,254		446,254	0	446,254	31.00
44.00	04400	SKILLED NURSING FACILITY	3,876,929		3,876,929	0	3,876,929	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,212,146		1,212,146	0	1,212,146	50.00
53.00	05300	ANESTHESIOLOGY	2,880		2,880	0	2,880	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,909,184		1,909,184	0	1,909,184	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	197,568		197,568	0	197,568	55.00
60.00	06000	LABORATORY	1,762,352		1,762,352	0	1,762,352	60.00
65.00	06500	RESPIRATORY THERAPY	510,481	0	510,481	0	510,481	65.00
66.00	06600	PHYSICAL THERAPY	820,689	0	820,689	0	820,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,032	0	113,032	0	113,032	67.00
68.00	06800	SPEECH PATHOLOGY	56,601	0	56,601	0	56,601	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,047,700		1,047,700	0	1,047,700	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	81,922		81,922	0	81,922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,409,667		1,409,667	0	1,409,667	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	678,646		678,646	0	678,646	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	215,163		215,163	0	215,163	88.01
90.00	09000	CLINIC	907,785		907,785	0	907,785	90.00
90.01	09002	WOUND CARE	143,784		143,784	0	143,784	90.01
91.00	09100	EMERGENCY	2,156,629		2,156,629	0	2,156,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	423,043		423,043		423,043	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	255,724		255,724	0	255,724	95.00
200.00		Subtotal (see instructions)	20,497,585	0	20,497,585	0	20,497,585	200.00
201.00		Less Observation Beds	423,043		423,043		423,043	201.00
202.00		Total (see instructions)	20,074,542	0	20,074,542	0	20,074,542	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,240,112		2,240,112			30.00
31.00	03100	INTENSIVE CARE UNIT	204,884		204,884			31.00
44.00	04400	SKILLED NURSING FACILITY	3,548,999		3,548,999			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	104,579	2,075,941	2,180,520	0.555898	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	533,083	12,148,309	12,681,392	0.150550	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	26,698	698,116	724,814	0.272578	0.000000	55.00
60.00	06000	LABORATORY	1,144,096	10,943,432	12,087,528	0.145799	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	766,157	1,368,899	2,135,056	0.239095	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	343,219	1,202,186	1,545,405	0.531051	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,902	124,037	205,939	0.548862	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,615	44,030	60,645	0.933317	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,721,742	1,133,416	2,855,158	0.366950	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,978	54,434	59,412	1.378880	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,156,188	3,709,839	5,866,027	0.240310	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	210,492	210,492			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	147,848	147,848			88.01
90.00	09000	CLINIC	0	1,932,470	1,932,470	0.469754	0.000000	90.00
90.01	09002	WOUND CARE	0	361,582	361,582	0.397653	0.000000	90.01
91.00	09100	EMERGENCY	113,500	6,686,740	6,800,240	0.317140	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,094	1,471,970	1,534,064	0.275766	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,254,357	1,254,357	0.203869	0.000000	95.00
200.00		Subtotal (see instructions)	13,068,846	45,568,098	58,636,944			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,068,846	45,568,098	58,636,944			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09002	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,269,406		2,269,406	0	2,269,406	30.00
31.00	03100	INTENSIVE CARE UNIT	446,254		446,254	0	446,254	31.00
44.00	04400	SKILLED NURSING FACILITY	3,876,929		3,876,929	0	3,876,929	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,212,146		1,212,146	0	1,212,146	50.00
53.00	05300	ANESTHESIOLOGY	2,880		2,880	0	2,880	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,909,184		1,909,184	0	1,909,184	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	197,568		197,568	0	197,568	55.00
60.00	06000	LABORATORY	1,762,352		1,762,352	0	1,762,352	60.00
65.00	06500	RESPIRATORY THERAPY	510,481	0	510,481	0	510,481	65.00
66.00	06600	PHYSICAL THERAPY	820,689	0	820,689	0	820,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,032	0	113,032	0	113,032	67.00
68.00	06800	SPEECH PATHOLOGY	56,601	0	56,601	0	56,601	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,047,700		1,047,700	0	1,047,700	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	81,922		81,922	0	81,922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,409,667		1,409,667	0	1,409,667	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	678,646		678,646	0	678,646	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	215,163		215,163	0	215,163	88.01
90.00	09000	CLINIC	907,785		907,785	0	907,785	90.00
90.01	09002	WOUND CARE	143,784		143,784	0	143,784	90.01
91.00	09100	EMERGENCY	2,156,629		2,156,629	0	2,156,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	423,043		423,043		423,043	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	255,724		255,724	0	255,724	95.00
200.00		Subtotal (see instructions)	20,497,585	0	20,497,585	0	20,497,585	200.00
201.00		Less Observation Beds	423,043		423,043		423,043	201.00
202.00		Total (see instructions)	20,074,542	0	20,074,542	0	20,074,542	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,240,112		2,240,112			30.00
31.00	03100	INTENSIVE CARE UNIT	204,884		204,884			31.00
44.00	04400	SKILLED NURSING FACILITY	3,548,999		3,548,999			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	104,579	2,075,941	2,180,520	0.555898	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	533,083	12,148,309	12,681,392	0.150550	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	26,698	698,116	724,814	0.272578	0.000000	55.00
60.00	06000	LABORATORY	1,144,096	10,943,432	12,087,528	0.145799	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	766,157	1,368,899	2,135,056	0.239095	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	343,219	1,202,186	1,545,405	0.531051	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,902	124,037	205,939	0.548862	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,615	44,030	60,645	0.933317	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,721,742	1,133,416	2,855,158	0.366950	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,978	54,434	59,412	1.378880	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,156,188	3,709,839	5,866,027	0.240310	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	210,492	210,492	3.224094	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	147,848	147,848	1.455299	0.000000	88.01
90.00	09000	CLINIC	0	1,932,470	1,932,470	0.469754	0.000000	90.00
90.01	09002	WOUND CARE	0	361,582	361,582	0.397653	0.000000	90.01
91.00	09100	EMERGENCY	113,500	6,686,740	6,800,240	0.317140	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,094	1,471,970	1,534,064	0.275766	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,254,357	1,254,357	0.203869	0.000000	95.00
200.00		Subtotal (see instructions)	13,068,846	45,568,098	58,636,944			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,068,846	45,568,098	58,636,944			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09002	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/15/2015 3:25 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	86,188	2,180,520	0.039526	68,858	2,722	50.00
53.00	05300	ANESTHESIOLOGY	43	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,406	12,681,392	0.011939	152,348	1,819	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,381	724,814	0.004665	17,925	84	55.00
60.00	06000	LABORATORY	58,933	12,087,528	0.004876	531,517	2,592	60.00
65.00	06500	RESPIRATORY THERAPY	51,664	2,135,056	0.024198	355,644	8,606	65.00
66.00	06600	PHYSICAL THERAPY	54,004	1,545,405	0.034945	56,167	1,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,333	205,939	0.025896	8,185	212	67.00
68.00	06800	SPEECH PATHOLOGY	2,713	60,645	0.044736	2,589	116	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,818	2,855,158	0.007992	1,014,895	8,111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,697	59,412	0.028563	4,978	142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,936	5,866,027	0.007149	854,704	6,110	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	11,069	210,492	0.052586	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	3,644	147,848	0.024647	0	0	88.01
90.00	09000	CLINIC	65,115	1,932,470	0.033695	0	0	90.00
90.01	09002	WOUND CARE	2,363	361,582	0.006535	0	0	90.01
91.00	09100	EMERGENCY	76,961	6,800,240	0.011317	240	3	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,974	1,534,064	0.024754	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	677,242	51,388,592		3,068,050	32,480	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,180,520	0.000000	0.000000	68,858	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,681,392	0.000000	0.000000	152,348	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	724,814	0.000000	0.000000	17,925	55.00
60.00	06000	LABORATORY	0	12,087,528	0.000000	0.000000	531,517	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,135,056	0.000000	0.000000	355,644	65.00
66.00	06600	PHYSICAL THERAPY	0	1,545,405	0.000000	0.000000	56,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	205,939	0.000000	0.000000	8,185	67.00
68.00	06800	SPEECH PATHOLOGY	0	60,645	0.000000	0.000000	2,589	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,855,158	0.000000	0.000000	1,014,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	59,412	0.000000	0.000000	4,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,866,027	0.000000	0.000000	854,704	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	210,492	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	147,848	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	1,932,470	0.000000	0.000000	0	90.00
90.01	09002	WOUND CARE	0	361,582	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,800,240	0.000000	0.000000	240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,534,064	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	51,388,592			3,068,050	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
90.01	09002	WOUND CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/15/2015 3:25 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	0.555898	0	1,060,341	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	360	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150550	0	4,350,389	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272578	0	426,037	0	0	55.00
60.00	06000	LABORATORY	0.145799	0	5,337,696	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.239095	0	866,301	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.531051	0	486,739	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548862	0	19,457	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.933317	0	11,031	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366950	0	343,671	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.378880	0	41,417	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240310	0	2,652,002	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000				0	88.01
90.00	09000	CLINIC	0.469754	0	1,823,785	0	0	90.00
90.01	09002	WOUND CARE	0.397653	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.317140	0	1,667,796	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.275766	0	295,613	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.203869		0			95.00
200.00		Subtotal (see instructions)		0	19,382,635	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	19,382,635	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/15/2015 3:25 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	589,441	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	654,951	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	116,128	0	55.00
60.00	06000	LABORATORY	778,231	0	60.00
65.00	06500	RESPIRATORY THERAPY	207,128	0	65.00
66.00	06600	PHYSICAL THERAPY	258,483	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,679	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,295	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,110	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	57,109	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	637,303	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	88.01
90.00	09000	CLINIC	856,730	0	90.00
90.01	09002	WOUND CARE	0	0	90.01
91.00	09100	EMERGENCY	528,925	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	81,520	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,913,033	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,913,033	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/15/2015 3:25 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	0.555898	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150550	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272578	0	0	0	0	55.00
60.00	06000	LABORATORY	0.145799	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.239095	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.531051	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548862	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.933317	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366950	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.378880	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240310	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000				0	88.01
90.00	09000	CLINIC	0.469754	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.397653	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.317140	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.275766	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.203869		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Swing Beds - SNF | Cost

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,180,520	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,681,392	0.000000	0.000000	3,251	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	724,814	0.000000	0.000000	0	55.00
60.00	06000	LABORATORY	0	12,087,528	0.000000	0.000000	12,560	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,135,056	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,545,405	0.000000	0.000000	28,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	205,939	0.000000	0.000000	15,089	67.00
68.00	06800	SPEECH PATHOLOGY	0	60,645	0.000000	0.000000	3,135	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,855,158	0.000000	0.000000	15,501	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	59,412	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,866,027	0.000000	0.000000	58,001	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	210,492	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	147,848	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	1,932,470	0.000000	0.000000	0	90.00
90.01	09002	WOUND CARE	0	361,582	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,800,240	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,534,064	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	51,388,592			135,878	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
90.01	09002	WOUND CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.555898	0	245,453	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150550	0	2,217,097	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272578	0	86,376	0	0	55.00
60.00	06000	LABORATORY	0.145799	0	1,336,520	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.239095	0	90,233	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.531051	0	177,804	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548862	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.933317	0	307	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366950	0	175,913	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.378880	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240310	0	474,921	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	3.224094				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	1.455299				0	88.01
90.00	09000	CLINIC	0.469754	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.397653	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.317140	0	1,963,402	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.275766	0	86,058	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.203869	0	0			95.00
200.00		Subtotal (see instructions)		0	6,854,084	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	6,854,084	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	136,447	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	333,784	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	23,544	0		55.00
60.00	06000	LABORATORY	194,863	0		60.00
65.00	06500	RESPIRATORY THERAPY	21,574	0		65.00
66.00	06600	PHYSICAL THERAPY	94,423	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	287	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,551	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,128	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09002	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	622,673	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,732	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,630,006	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,630,006	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/15/2015 3:25 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)	3,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,191	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,572	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,104	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	105	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)	978	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	1,104	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	166.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,269,406	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)	17,514	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)	772,021	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,497,385	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,497,385	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)	683.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	668,395	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)	668,395	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	446,254	130	3,432.72	96	329,541	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)	850,114	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,848,050	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)	754,507	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	754,507	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)	619	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	683.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	423,043	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/15/2015 3:25 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	134,410	1,497,385	0.089763	423,043	37,974	90.00
91.00	Nursing School cost	0	1,497,385	0.000000	423,043	0	91.00
92.00	Allied health cost	0	1,497,385	0.000000	423,043	0	92.00
93.00	All other Medical Education	0	1,497,385	0.000000	423,043	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141346 Component CCN: 145499	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/15/2015 3:25 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,597	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,597	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	20,597	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)	154	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	166.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,876,929	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,876,929	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,876,929	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	3,876,929	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	188.23	71.00
72.00	Program routine service cost (line 9 x line 71)	28,987	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)	28,987	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)	28,987	83.00
84.00	Program inpatient ancillary services (see instructions)	48,205	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)	77,192	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,191	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,572	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,104	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	105	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)	219	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	166.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,269,406	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)	17,514	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)	772,021	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,497,385	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,497,385	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)	683.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	149,671	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)	149,671	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	446,254	130	3,432.72	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	138,253	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	287,924	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	619	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	683.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	423,043	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	134,410	1,497,385	0.089763	423,043	37,974	90.00
91.00	Nursing School cost	0	1,497,385	0.000000	423,043	0	91.00
92.00	Allied health cost	0	1,497,385	0.000000	423,043	0	92.00
93.00	All other Medical Education	0	1,497,385	0.000000	423,043	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/15/2015 3:25 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		960,502		30.00
31.00	03100	INTENSIVE CARE UNIT		142,324		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.555898	68,858	38,278	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150550	152,348	22,936	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272578	17,925	4,886	55.00
60.00	06000	LABORATORY	0.145799	531,517	77,495	60.00
65.00	06500	RESPIRATORY THERAPY	0.239095	355,644	85,033	65.00
66.00	06600	PHYSICAL THERAPY	0.531051	56,167	29,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548862	8,185	4,492	67.00
68.00	06800	SPEECH PATHOLOGY	0.933317	2,589	2,416	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366950	1,014,895	372,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.378880	4,978	6,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240310	854,704	205,394	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000		0	88.01
90.00	09000	CLINIC	0.469754	0	0	90.00
90.01	09002	WOUND CARE	0.397653	0	0	90.01
91.00	09100	EMERGENCY	0.317140	240	76	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.275766	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)		3,068,050	850,114	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,068,050		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 14Z346 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.555898	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150550	48,220	7,260	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272578	0	0	55.00
60.00	06000	LABORATORY	0.145799	171,285	24,973	60.00
65.00	06500	RESPIRATORY THERAPY	0.239095	167,155	39,966	65.00
66.00	06600	PHYSICAL THERAPY	0.531051	199,302	105,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548862	45,138	24,775	67.00
68.00	06800	SPEECH PATHOLOGY	0.933317	9,422	8,794	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366950	213,833	78,466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.378880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240310	656,021	157,648	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000		0	88.01
90.00	09000	CLINIC	0.469754	0	0	90.00
90.01	09002	WOUND CARE	0.397653	0	0	90.01
91.00	09100	EMERGENCY	0.317140	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.275766	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)		1,510,376	447,722	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)		1,510,376		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 145499 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.555898	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150550	3,251	489	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272578	0	0	55.00
60.00	06000	LABORATORY	0.145799	12,560	1,831	60.00
65.00	06500	RESPIRATORY THERAPY	0.239095	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.531051	28,341	15,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548862	15,089	8,282	67.00
68.00	06800	SPEECH PATHOLOGY	0.933317	3,135	2,926	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366950	15,501	5,688	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.378880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240310	58,001	13,938	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0.000000		0	88.01
90.00	09000	CLINIC	0.469754	0	0	90.00
90.01	09002	WOUND CARE	0.397653	0	0	90.01
91.00	09100	EMERGENCY	0.317140	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.275766	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)		135,878	48,205	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)		135,878		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/15/2015 3:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		177,665		30.00
31.00	03100	INTENSIVE CARE UNIT		19,852		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.555898	6,440	3,580	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150550	80,395	12,103	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272578	7,888	2,150	55.00
60.00	06000	LABORATORY	0.145799	136,806	19,946	60.00
65.00	06500	RESPIRATORY THERAPY	0.239095	114,545	27,387	65.00
66.00	06600	PHYSICAL THERAPY	0.531051	3,188	1,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548862	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.933317	254	237	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.366950	12,148	4,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.378880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240310	179,858	43,222	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	3.224094	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	1.455299	0	0	88.01
90.00	09000	CLINIC	0.469754	0	0	90.00
90.01	09002	WOUND CARE	0.397653	0	0	90.01
91.00	09100	EMERGENCY	0.317140	53,072	16,831	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.275766	24,099	6,646	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		618,693	138,253	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		618,693		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/15/2015 3:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,913,033	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 Wkst. D, Pt. IV, col. 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)	4,913,033	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 Wkst. D-4, Pt. 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)	4,962,163	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)	43,818	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,805,817	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,112,528	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,112,528	30.00
31.00	Primary payer payments	881	31.00
32.00	Subtotal (line 30 minus line 31)	2,111,647	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	762,956	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	579,847	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	686,278	36.00
37.00	Subtotal (see instructions)	2,691,494	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,691,494	40.00
40.01	Sequestration adjustment (see instructions)	53,830	40.01
41.00	Interim payments	2,726,750	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-89,086	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,256,140		2,726,750	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,256,140		2,726,750	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		337,216		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		89,086	6.02
7.00	Total Medicare program liability (see instructions)		1,593,356		2,637,664	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/15/2015 3:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,035,223		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,035,223		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		143,720		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,178,943		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/15/2015 3:25 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		46,622		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		46,622		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		5,964		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		52,586		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141346	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/15/2015 3:25 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, Pt. I col. 15 line 14	570	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,074	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	92	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,702	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	58,636,944	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	100,334	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	880,614	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	780,488	8.00
9.00	Sequestration adjustment amount (see instructions)	15,610	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	764,878	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)	764,878	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141346 Component CCN: 14Z346	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/15/2015 3:25 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)	762,052	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	452,199	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,104	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)	1,214,251	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,214,251	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)	1,214,251	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,248	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)	1,203,003	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
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)	1,203,003	0	19.00
19.01	Sequestration adjustment (see instructions)	24,060	0	19.01
20.00	Interim payments	1,035,223	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)	143,720	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/15/2015 3:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,848,050	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,848,050	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,866,531	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)	1,866,531	19.00
20.00	Deductibles (exclude professional component)	289,302	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,577,229	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,577,229	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	64,005	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	48,644	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,859	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,625,873	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,625,873	30.00
30.01	Sequestration adjustment (see instructions)	32,517	30.01
31.00	Interim payments	1,256,140	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)	337,216	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: 141346 Component CCN: 145499	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VI Date/Time Prepared: 5/15/2015 3:25 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)	51,829	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)	51,829	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	4,256	7.00
8.00	Allowable bad debts (see instructions)	8,008	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	8,008	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	6,086	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	53,659	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	53,659	15.00
15.01	Sequestration adjustment (see instructions)	1,073	15.01
16.00	Interim payments	46,622	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	5,964	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: 141346	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/15/2015 3:25 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	287,924		1.00
2.00	Medical and other services		1,630,006	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	287,924	1,630,006	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)	287,924	1,630,006	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	618,693	6,854,084	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	618,693	6,854,084	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	618,693	6,854,084	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	330,769	5,224,078	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)	287,924	1,630,006	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)	287,924	1,630,006	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)	287,924	1,630,006	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)	287,924	1,630,006	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	287,924	1,630,006	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)	287,924	1,630,006	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	287,924	1,630,006	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: 141346 Component CCN: 145499	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/15/2015 3:25 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: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/15/2015 3:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,226,646	0	0	0	1.00
2.00	Temporary investments	1,022,870	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,726,097	0	0	0	4.00
5.00	Other receivable	1,601,797	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,958,000	0	0	0	6.00
7.00	Inventory	301,899	0	0	0	7.00
8.00	Prepaid expenses	339,845	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	16,667	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,277,821	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	29,201,624	0	0	0	19.00
20.00	Accumulated depreciation	-19,595,940	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,605,684	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,415	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,415	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,887,920	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,280,139	0	0	0	37.00
38.00	Salaries, wages, and fees payable	859,090	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,239,156	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,378,385	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,378,385	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	17,509,535				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)	17,509,535	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,887,920	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/15/2015 3:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,974,881		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,672,340				2.00
3.00	Total (sum of line 1 and line 2)		17,647,221		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,647,221		0		11.00
12.00	Deductions	137,686		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)		137,686		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,509,535		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/15/2015 3:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,021,681		3,021,681	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	3,504,600		3,504,600	6.00
7.00	SKILLED NURSING FACILITY	44,399		44,399	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,570,680		6,570,680	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	204,884		204,884	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)	204,884		204,884	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,775,564		6,775,564	17.00
18.00	Ancillary services	7,148,634	45,012,973	52,161,607	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC (RHC) VANDALIA	0	153,000	153,000	20.00
20.01	RURAL HEALTH CLINIC (RHC) ST ELMO	0	195,551	195,551	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,254,357	1,254,357	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	78,800	2,230,499	2,309,299	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,002,998	48,846,380	62,849,378	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,559,502		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	MEDICAID TAX ASSESSMENT	164,335			37.00
38.00	PHYSICIAN EXPENSE	2,334,587			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		2,498,922		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,060,580		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141346	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/15/2015 3:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,849,378	1.00
2.00	Less contractual allowances and discounts on patients' accounts	40,221,221	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,628,157	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,060,580	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-432,423	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,519,510	24.00
25.00	Total other income (sum of lines 6-24)	1,519,510	25.00
26.00	Total (line 5 plus line 25)	1,087,087	26.00
27.00	OTHER EXPENSES	-585,253	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-585,253	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,672,340	29.00

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

Provider CCN: 141346 Component CCN: 148527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/15/2015 3:25 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	146,637	0	146,637	0	146,637	1.00
2.00	Physician Assistant	68,732	0	68,732	0	68,732	2.00
3.00	Nurse Practitioner	2,446	0	2,446	0	2,446	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	126,074	0	126,074	0	126,074	9.00
10.00	Subtotal (sum of lines 1 through 9)	343,889	0	343,889	0	343,889	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 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	100,165	100,165	0	100,165	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	100,165	100,165	0	100,165	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	343,889	100,165	444,054	0	444,054	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 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	343,889	100,165	444,054	0	444,054	32.00

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

Provider CCN: 141346 Component CCN: 148527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/15/2015 3:25 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	146,637		1.00
2.00	Physician Assistant	0	68,732		2.00
3.00	Nurse Practitioner	0	2,446		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	-614	125,460		9.00
10.00	Subtotal (sum of lines 1 through 9)	-614	343,275		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 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	100,165		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	100,165		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-614	443,440		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 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-614	443,440		32.00

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

Provider CCN: 141346 Component CCN: 148528 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/15/2015 3:25 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	30,327	0	30,327	0	30,327	1.00
2.00	Physician Assistant	49,192	0	49,192	0	49,192	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	32,405	0	32,405	-1,004	31,401	9.00
10.00	Subtotal (sum of lines 1 through 9)	111,924	0	111,924	-1,004	110,920	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 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	28,127	28,127	0	28,127	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,127	28,127	0	28,127	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	111,924	28,127	140,051	-1,004	139,047	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 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	111,924	28,127	140,051	-1,004	139,047	32.00

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

Provider CCN: 141346 | Component CCN: 148528 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/15/2015 3:25 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	30,327		1.00
2.00	Physician Assistant	0	49,192		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	-2,436	28,965		9.00
10.00	Subtotal (sum of lines 1 through 9)	-2,436	108,484		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 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	28,127		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,127		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-2,436	136,611		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 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,436	136,611		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2

Component CCN: 148527 | Date/Time Prepared: 5/15/2015 3:25 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.72	1,163	4,200	3,024		1.00
2.00	Physician Assistant	0.56	1,174	2,100	1,176		2.00
3.00	Nurse Practitioner	0.03	101	2,100	63		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.31	2,438		4,263	4,263	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 through 7)	1.31	2,438			4,263	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 Wkst. M-1, col. 7, line 22)					443,440	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					443,440	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 Wkst. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					235,206	15.00
16.00	Total overhead (sum of lines 14 and 15)					235,206	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					235,206	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					235,206	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					678,646	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141346 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2

Component CCN: 148528 | Date/Time Prepared: 5/15/2015 3:25 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	0.15	221	4,200	630		1.00
2.00	Physician Assistant	0.39	1,233	2,100	819		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.54	1,454		1,449	1,454	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 through 7)	0.54	1,454			1,454	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 Wkst. M-1, col. 7, line 22)					136,611	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					136,611	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 Wkst. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					78,552	15.00
16.00	Total overhead (sum of lines 14 and 15)					78,552	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					78,552	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					78,552	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					215,163	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141346 | Component CCN: 148527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 5/15/2015 3:25 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 Wkst. M-2, line 20)		678,646	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		678,646	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,263	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,263	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		159.19	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)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	159.19	159.19	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	5	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	796	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) *		796	16.00
16.01	Total program charges (see instructions)(from contractor's records)		537	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.)		258	16.04
16.05	Total program cost (see instructions)		258	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		473	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		13	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		258	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		258	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
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		258	26.00
26.01	Sequestration adjustment (see instructions)		5	26.01
27.00	Interim payments		-76	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)		329	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141346 Component CCN: 148528	Period: From 01/01/2014 To 12/31/2014	Worksheet M-3 Date/Time Prepared: 5/15/2015 3:25 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 Wkst. M-2, line 20)		215,163	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		215,163	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,454	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,454	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		147.98	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)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	147.98	147.98	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	296	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) *		296	16.00
16.01	Total program charges (see instructions)(from contractor's records)		262	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.)		77	16.04
16.05	Total program cost (see instructions)		77	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		200	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		77	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		77	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
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		77	26.00
26.01	Sequestration adjustment (see instructions)		2	26.01
27.00	Interim payments		-41	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)		116	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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

Provider CCN: 141346 | Component CCN: 148527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 5/15/2015 3:25 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		-76	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		-76	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		329	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		253	7.00

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

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

Provider CCN: 141346 | Component CCN: 148528 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 5/15/2015 3:25 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		-41	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		-41	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		116	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		75	7.00

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