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 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/2/2016 2:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/2/2016 Time: 2:05 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 01/01/2015 and ending 12/31/2015 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	99,654	-173,175	0	2,960,040	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	215,702	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC (RHC) VANDALIA I	0		77,235		0	10.00
10.01	RURAL HEALTH CLINIC (RHC) ST ELMO II	0		8,821		0	10.01
200.00	Total	0	315,356	-87,119	0	2,960,040	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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/2/2016 2:03 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	99914	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	99914		04/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAYETTE COUNTY SNF	145499	99914		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	99914		06/01/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CONFIDENCE MEDICAL - ST ELMO	148528	99914		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)	01/01/2015	12/31/2015	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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/2/2016 2:03 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 is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the 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, chapter 21, §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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/2/2016 2:03 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, indicate which program year began during this cost reporting period. (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, indicate which program year began during this cost reporting period. (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
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID 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

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		V	XIX	
		1.00	2.00	
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	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 is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/2/2016 2:03 pm

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
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, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
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 §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015	12/31/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141346	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/2/2016 2:03 pm

		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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/2/2016 2:03 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 Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program 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	01/08/2016	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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/2/2016 2:03 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)	01/08/2016			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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/2/2016 2:03 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	37,320.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	37,320.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	2,040.00	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	39,360.00	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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/2/2016 2:03 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)	928	212	1,555			1.00
2.00	HMO and other (see instructions)	30	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	1,020	0	1,020			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		173	173			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,948	385	2,748			7.00
8.00	INTENSIVE CARE UNIT	92	0	92			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)	2,040	385	2,840	0.00	159.91	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	0	10,004	17,573	0.00	34.15	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	619	0	1,712	0.00	3.18	26.00
26.01	RURAL HEALTH CLINIC (RHC) ST ELMO	339	0	1,615	0.00	1.34	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	487			28.00
29.00	Ambulance Trips	409					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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/2/2016 2:03 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	319	67	524	1.00
2.00	HMO and other (see instructions)			9	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		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	319	67	524	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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/2/2016 2:03 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	99,435	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)	2,844,694	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	55,040	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,412	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)	46,725	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	212,410	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	647,862	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	71,032	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	19,114	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,007,724	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 01/01/2015 To 12/31/2015 | Worksheet S-7 | Date/Time Prepared: 5/2/2016 2:03 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	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	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	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-7 | Date/Time Prepared: 5/2/2016 2:03 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		0	0	0	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)	3,187,728			207.00

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

Provider CCN: 141346 Component CCN: 148527 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/2/2016 2:03 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)						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 01/01/2015
To 12/31/2015

Worksheet S-8
Date/Time Prepared:
5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/2/2016 2:03 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)						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 01/01/2015
To 12/31/2015

Worksheet S-8
Date/Time Prepared:
5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/2/2016 2:03 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)	0.337110	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,904,776	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,456,756	5.00
6.00	Medicaid charges	17,114,245	6.00
7.00	Medicaid cost (line 1 times line 6)	5,769,383	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)	407,851	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)	407,851	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	158,328	0	158,328	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	53,374	0	53,374	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)	53,374	0	53,374	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,868,200	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	354,048	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,514,152	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	847,546	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	900,920	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,308,771	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/2/2016 2:03 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		1,583,622	1,583,622	-620,983	962,639	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	679,553	679,553	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	74,788	3,496,695	3,571,483	5,800	3,577,283	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	661,879	2,393,331	3,055,210	37,171	3,092,381	5.00
7.00	00700	OPERATION OF PLANT	252,949	69,591	322,540	23,363	345,903	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	574,884	574,884	0	574,884	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	13,637	13,637	0	13,637	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	76,983	52,532	129,515	0	129,515	8.00
9.00	00900	HOUSEKEEPING	376,899	102,510	479,409	0	479,409	9.00
10.00	01000	DIETARY	316,441	383,793	700,234	-156,140	544,094	10.00
11.00	01100	CAFETERIA	0	0	0	156,140	156,140	11.00
13.00	01300	NURSING ADMINISTRATION	236,557	26,027	262,584	0	262,584	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,727	57,185	111,912	0	111,912	14.00
15.00	01500	PHARMACY	192,363	158,040	350,403	0	350,403	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	244,600	167,231	411,831	0	411,831	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	289,575	289,575	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,320,926	197,805	1,518,731	22,715	1,541,446	30.00
31.00	03100	INTENSIVE CARE UNIT	129,136	13,009	142,145	-34	142,111	31.00
44.00	04400	SKILLED NURSING FACILITY	1,282,084	461,360	1,743,444	-23,578	1,719,866	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	469,545	238,427	707,972	-60,576	647,396	50.00
53.00	05300	ANESTHESIOLOGY	0	292,721	292,721	-289,901	2,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,318	795,115	1,222,433	-5,676	1,216,757	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	165,091	165,091	-4,715	160,376	55.00
60.00	06000	LABORATORY	513,969	789,235	1,303,204	305	1,303,509	60.00
65.00	06500	RESPIRATORY THERAPY	184,093	98,341	282,434	-15,431	267,003	65.00
66.00	06600	PHYSICAL THERAPY	408,702	46,170	454,872	-37	454,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,021	5,161	71,182	0	71,182	67.00
68.00	06800	SPEECH PATHOLOGY	28,864	5,278	34,142	0	34,142	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	476,478	476,478	56,388	532,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	17,046	17,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	845,077	845,077	32,759	877,836	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	190,970	94,188	285,158	-61	285,097	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	98,394	41,998	140,392	-1,263	139,129	88.01
90.00	09000	CLINIC	0	596,582	596,582	-189	596,393	90.00
90.01	09002	WOUND CARE	0	163,125	163,125	0	163,125	90.01
91.00	09100	EMERGENCY	528,303	1,592,474	2,120,777	267,049	2,387,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	347,578	62,067	409,645	-280,453	129,192	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,484,089	16,058,780	24,542,869	128,827	24,671,696	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	1,620,958	760,441	2,381,399	-7,992	2,373,407	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	119,105	119,105	-120,835	-1,730	192.01
192.02	19202	PUBLIC RELATIONS	0	38,390	38,390	0	38,390	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)	10,105,047	16,976,716	27,081,763	0	27,081,763	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/2/2016 2:03 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	-384,855	577,784		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	679,553		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8	3,577,291		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-47,140	3,045,241		5.00
7.00	00700	OPERATION OF PLANT	-1,672	344,231		7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	574,884		7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	13,637		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,515		8.00
9.00	00900	HOUSEKEEPING	0	479,409		9.00
10.00	01000	DIETARY	-69,732	474,362		10.00
11.00	01100	CAFETERIA	0	156,140		11.00
13.00	01300	NURSING ADMINISTRATION	0	262,584		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	111,912		14.00
15.00	01500	PHARMACY	0	350,403		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,405	399,426		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-289,575	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-435,135	1,106,311		30.00
31.00	03100	INTENSIVE CARE UNIT	0	142,111		31.00
44.00	04400	SKILLED NURSING FACILITY	-153,990	1,565,876		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	647,396		50.00
53.00	05300	ANESTHESIOLOGY	0	2,820		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-448	1,216,309		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	160,376		55.00
60.00	06000	LABORATORY	0	1,303,509		60.00
65.00	06500	RESPIRATORY THERAPY	0	267,003		65.00
66.00	06600	PHYSICAL THERAPY	0	454,835		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	71,182		67.00
68.00	06800	SPEECH PATHOLOGY	0	34,142		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	532,866		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	17,046		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-55,521	822,315		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	285,097		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	139,129		88.01
90.00	09000	CLINIC	0	596,393		90.00
90.01	09002	WOUND CARE	0	163,125		90.01
91.00	09100	EMERGENCY	-1,118,184	1,269,642		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	129,192		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,568,649	22,103,047		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,373,407		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	-1,730		192.01
192.02	19202	PUBLIC RELATIONS	0	38,390		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)	-2,568,649	24,513,114		200.00

RECLASSIFICATIONS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/2/2016 2:03 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	70,561	85,579	1.00
	TOTALS		70,561	85,579	
	B - CRNA				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	289,575	1.00
	TOTALS		0	289,575	
	D - DEPRECIATION				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	679,553	1.00
	TOTALS		0	679,553	
	E - ER				
1.00	EMERGENCY	91.00	277,565	0	1.00
	TOTALS		277,565	0	
	G - INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,790	1.00
	TOTALS		0	16,790	
	H - EMPLOYEE OCC HEALTH PROCEDURES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	4,687	1,113	1.00
	TOTALS		4,687	1,113	
	I - WELLNESS DEPR AND UTILITIES				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	75,360	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	20,381	2.00
3.00	OPERATION OF PLANT	7.00	0	23,363	3.00
	TOTALS		0	119,104	
	J - MED SUPPLY				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	56,388	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	17,046	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	25,432	3.00
4.00	LABORATORY	60.00	0	305	4.00
5.00	RURAL HEALTH CLINIC (RHC) ST ELMO	88.01	0	122	5.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
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	99,293	
	K - PHARMACY				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	32,759	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	32,759	
500.00	Grand Total: Increases		352,813	1,323,766	500.00

RECLASSIFICATIONS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/2/2016 2:03 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	70,561	85,579	0		1.00
	TOTALS		70,561	85,579			
	B - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	289,575	0		1.00
	TOTALS		0	289,575			
	D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	679,553	9		1.00
	TOTALS		0	679,553			
	E - ER						
1.00	AMBULANCE SERVICES	95.00	277,565	0	0		1.00
	TOTALS		277,565	0			
	G - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	16,790	9		1.00
	TOTALS		0	16,790			
	H - EMPLOYEE OCC HEALTH PROCEDURES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	4,687	1,113	0		1.00
	TOTALS		4,687	1,113			
	I - WELLNESS DEPR AND UTILITIES						
1.00	FAYETTE COUNTY ANNEX	192.01	0	119,104	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	119,104			
	J - MED SUPPLY						
1.00		0.00	0	0	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	7,432	0		2.00
3.00	OPERATING ROOM	50.00	0	57,311	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	304	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,424	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	296	0		6.00
8.00	RESPIRATORY THERAPY	65.00	0	15,412	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	8	0		9.00
13.00	RURAL HEALTH CLINIC (RHC) VANDALIA	88.00	0	61	0		13.00
14.00	CLINIC	90.00	0	71	0		14.00
15.00	EMERGENCY	91.00	0	9,387	0		15.00
16.00	AMBULANCE SERVICES	95.00	0	515	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,341	0		17.00
18.00	FAYETTE COUNTY ANNEX	192.01	0	1,731	0		18.00
	TOTALS		0	99,293			
	K - PHARMACY						
1.00	ADULTS & PEDIATRICS	30.00	0	2,717	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	34	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	16,146	0		3.00
4.00	OPERATING ROOM	50.00	0	3,265	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	22	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	252	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	4,419	0		7.00
9.00	RESPIRATORY THERAPY	65.00	0	19	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	29	0		10.00
11.00	RURAL HEALTH CLINIC (RHC) ST ELMO	88.01	0	1,385	0		11.00
12.00	CLINIC	90.00	0	118	0		12.00
13.00	EMERGENCY	91.00	0	1,129	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	2,373	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	851	0		15.00
	TOTALS		0	32,759			
500.00	Grand Total: Decreases		352,813	1,323,766			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/2/2016 2:03 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	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	29,201,624	4,251,512	0	4,251,512	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,201,624	4,251,512	0	4,251,512	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,201,624	4,251,512	0	4,251,512	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	33,453,136	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,453,136	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,453,136	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/2/2016 2:03 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	1,583,622	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)	1,583,622	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	1,583,622		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	1,583,622		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/2/2016 2:03 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	33,453,136	0	33,453,136	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)	33,453,136	0	33,453,136	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	577,784	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	679,553	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,257,337	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	577,784	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	679,553	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,257,337	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/2/2016 2:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-32,949	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,289	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	-1,553,319			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	-448			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-69,732	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	-12,405	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	-1,672	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	-289,575	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	-384,855	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/2/2016 2:03 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	-11,902	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	EMPLOYEE BENEFIT OTHER REVENUE	A	8	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			0		0.00	0	35.00
36.00	LTC ASSESSMENT	A	-153,990	SKILLED NURSING FACILITY	44.00	0	36.00
37.00			0		0.00	0	37.00
38.00			0		0.00	0	38.00
39.00	340B EXPENSES	A	-55,521	DRUGS CHARGED TO PATIENTS	73.00	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.)		-2,568,649				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 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/2/2016 2:03 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	677,763	677,763	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	BLUE GRASS LEASING	65,171	65,171	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ALLIANT PURCHASING	7,020	7,020	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HEARTLAND ST ELMO	16,100	16,100	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	BLUE	67,539	67,539	4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	145,658	146,106	4.01
5.00	0		0	979,251	979,699	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	HEARTLAND STELM	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 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/2/2016 2:03 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	-448	0		4.01
5.00	-448			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 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/2/2016 2:03 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	1,484,040	1,118,184	365,856	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	435,135	435,135	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			1,919,175	1,553,319	365,856		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	1,118,184		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	435,135		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	1,553,319		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/2/2016 2:03 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	577,784	577,784				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	679,553		679,553			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,577,291	5,023	1,041	3,583,355		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,045,241	52,692	464,848	236,570	3,799,351	5.00
7.00	00700	OPERATION OF PLANT	344,231	69,815	15,206	90,410	519,662	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	574,884	0	0	0	574,884	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	13,637	0	0	0	13,637	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	129,515	12,870	1,638	27,515	171,538	8.00
9.00	00900	HOUSEKEEPING	479,409	2,333	0	134,712	616,454	9.00
10.00	01000	DIETARY	474,362	8,612	3,657	87,883	574,514	10.00
11.00	01100	CAFETERIA	156,140	10,107	0	25,220	191,467	11.00
13.00	01300	NURSING ADMINISTRATION	262,584	2,919	0	84,551	350,054	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,912	3,321	0	19,561	134,794	14.00
15.00	01500	PHARMACY	350,403	5,525	4,820	68,755	429,503	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	399,426	19,724	1,173	87,425	507,748	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,106,311	48,629	6,260	472,128	1,633,328	30.00
31.00	03100	INTENSIVE CARE UNIT	142,111	5,715	0	46,156	193,982	31.00
44.00	04400	SKILLED NURSING FACILITY	1,565,876	114,096	3,623	458,245	2,141,840	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	647,396	31,801	25,430	167,826	872,453	50.00
53.00	05300	ANESTHESIOLOGY	2,820	0	0	0	2,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,216,309	25,093	54,298	152,733	1,448,433	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	160,376	0	0	0	160,376	55.00
60.00	06000	LABORATORY	1,303,509	9,951	50,017	183,704	1,547,181	60.00
65.00	06500	RESPIRATORY THERAPY	267,003	16,587	8,619	65,799	358,008	65.00
66.00	06600	PHYSICAL THERAPY	454,835	28,302	3,045	146,079	632,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,182	1,518	0	23,597	96,297	67.00
68.00	06800	SPEECH PATHOLOGY	34,142	1,049	0	10,317	45,508	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	532,866	0	0	0	532,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,046	0	0	0	17,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	822,315	0	0	0	822,315	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	285,097	0	0	68,257	353,354	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	139,129	0	0	35,168	174,297	88.01
90.00	09000	CLINIC	596,393	29,709	0	0	626,102	90.00
90.01	09002	WOUND CARE	163,125	0	0	0	163,125	90.01
91.00	09100	EMERGENCY	1,269,642	20,483	286	288,035	1,578,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	129,192	5,899	10,101	25,024	170,216	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,103,047	531,773	654,062	3,005,670	21,453,860	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,718	0	0	2,718	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,373,407	37,282	14,397	577,685	3,002,771	192.00
192.01	19201	FAYETTE COUNTY ANNEX	-1,730	6,011	11,094	0	15,375	192.01
192.02	19202	PUBLIC RELATIONS	38,390	0	0	0	38,390	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)	24,513,114	577,784	679,553	3,583,355	24,513,114	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/2/2016 2:03 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	3,799,351					5.00
7.00	00700	OPERATION OF PLANT	95,317	614,979				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	105,446	0	680,330			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	2,501	0	0	16,138		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	31,464	17,812	20,820	0	241,634	8.00
9.00	00900	HOUSEKEEPING	113,071	3,229	3,774	0	14,104	9.00
10.00	01000	DIETARY	105,379	11,918	13,931	0	2,675	10.00
11.00	01100	CAFETERIA	35,119	13,989	16,351	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	64,208	4,040	4,722	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,724	4,596	5,372	0	0	14.00
15.00	01500	PHARMACY	78,780	7,647	8,939	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,132	27,297	31,908	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	299,588	67,301	78,668	0	43,633	30.00
31.00	03100	INTENSIVE CARE UNIT	35,581	7,910	9,246	0	3	31.00
44.00	04400	SKILLED NURSING FACILITY	392,861	157,905	184,577	0	118,914	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	160,027	44,013	51,446	0	10,447	50.00
53.00	05300	ANESTHESIOLOGY	517	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	265,674	34,728	40,594	0	3,847	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	29,416	0	0	0	0	55.00
60.00	06000	LABORATORY	283,787	13,772	16,098	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	65,667	22,956	26,834	0	27	65.00
66.00	06600	PHYSICAL THERAPY	115,971	39,170	45,785	0	10,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,663	2,101	2,456	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,347	1,452	1,697	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,739	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,127	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,831	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	64,813	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	31,970	0	0	0	0	88.01
90.00	09000	CLINIC	114,841	41,116	0	16,138	0	90.00
90.01	09002	WOUND CARE	29,921	0	0	0	0	90.01
91.00	09100	EMERGENCY	289,522	28,348	33,136	0	20,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	31,221	0	9,543	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,238,225	551,300	605,897	16,138	224,608	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	499	3,762	4,397	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	550,765	51,598	60,312	0	41	192.00
192.01	19201	FAYETTE COUNTY ANNEX	2,820	8,319	9,724	0	982	192.01
192.02	19202	PUBLIC RELATIONS	7,042	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	16,003	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)	3,799,351	614,979	680,330	16,138	241,634	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/2/2016 2:03 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	750,632					9.00
10.00	01000	DIETARY	14,859	723,276				10.00
11.00	01100	CAFETERIA	17,439	0	274,365			11.00
13.00	01300	NURSING ADMINISTRATION	5,036	0	13,019	441,079		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,730	0	4,456	0	179,672	14.00
15.00	01500	PHARMACY	9,533	0	5,355	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,031	0	11,118	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	83,903	136,362	37,055	163,298	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,861	3,092	4,517	19,906	0	31.00
44.00	04400	SKILLED NURSING FACILITY	196,859	541,985	72,310	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,870	0	13,632	60,078	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,295	0	16,616	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	17,170	0	23,034	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	28,619	0	7,297	0	0	65.00
66.00	06600	PHYSICAL THERAPY	48,832	0	12,345	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,619	0	1,390	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,810	0	777	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	163,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	16,315	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	28,643	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	12,070	0	88.01
90.00	09000	CLINIC	51,259	41,837	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	35,341	0	31,925	140,691	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,179	0	3,720	16,393	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	671,245	723,276	258,566	441,079	179,672	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,690	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,326	0	15,799	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	10,371	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)	750,632	723,276	274,365	441,079	179,672	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/2/2016 2:03 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	539,757					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	705,234				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	38,676	0	2,581,812	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	836	0	284,934	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	34,618	0	3,841,869	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	25,376	0	1,292,342	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,337	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	146,802	0	1,999,989	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,964	0	196,756	0	55.00
60.00	06000	LABORATORY	0	139,522	0	2,040,564	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,514	0	532,922	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,403	0	925,392	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,853	0	125,379	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	737	0	60,328	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,258	0	825,220	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	730	0	37,218	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	539,757	64,459	0	1,577,362	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	1,664	0	448,474	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	1,862	0	220,199	0	88.01
90.00	09000	CLINIC	0	22,581	0	913,874	0	90.00
90.01	09002	WOUND CARE	0	5,229	0	198,275	0	90.01
91.00	09100	EMERGENCY	0	78,705	0	2,236,447	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,113	0	256,385	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	539,757	661,902	0	20,599,078	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,066	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,332	0	3,788,944	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	47,591	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	45,432	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	16,003	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)	539,757	705,234	0	24,513,114	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/2/2016 2:03 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	2,581,812		30.00
31.00	03100	INTENSIVE CARE UNIT	284,934		31.00
44.00	04400	SKILLED NURSING FACILITY	3,841,869		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,292,342		50.00
53.00	05300	ANESTHESIOLOGY	3,337		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,999,989		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	196,756		55.00
60.00	06000	LABORATORY	2,040,564		60.00
65.00	06500	RESPIRATORY THERAPY	532,922		65.00
66.00	06600	PHYSICAL THERAPY	925,392		66.00
67.00	06700	OCCUPATIONAL THERAPY	125,379		67.00
68.00	06800	SPEECH PATHOLOGY	60,328		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	825,220		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,218		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,577,362		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	448,474		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	220,199		88.01
90.00	09000	CLINIC	913,874		90.00
90.01	09002	WOUND CARE	198,275		90.01
91.00	09100	EMERGENCY	2,236,447		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	256,385		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,599,078		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,066		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,788,944		192.00
192.01	19201	FAYETTE COUNTY ANNEX	47,591		192.01
192.02	19202	PUBLIC RELATIONS	45,432		192.02
192.03	19203	PERSONAL LAUNDRY	16,003		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)	24,513,114		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/2/2016 2:03 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	5,023	1,041	6,064	6,064	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	52,692	464,848	517,540	400	5.00
7.00	00700	OPERATION OF PLANT	0	69,815	15,206	85,021	153	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	12,870	1,638	14,508	47	8.00
9.00	00900	HOUSEKEEPING	0	2,333	0	2,333	228	9.00
10.00	01000	DIETARY	0	8,612	3,657	12,269	149	10.00
11.00	01100	CAFETERIA	0	10,107	0	10,107	43	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,919	0	2,919	143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,321	0	3,321	33	14.00
15.00	01500	PHARMACY	0	5,525	4,820	10,345	116	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,724	1,173	20,897	148	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	48,629	6,260	54,889	799	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,715	0	5,715	78	31.00
44.00	04400	SKILLED NURSING FACILITY	0	114,096	3,623	117,719	776	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,801	25,430	57,231	284	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,093	54,298	79,391	259	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	9,951	50,017	59,968	311	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,587	8,619	25,206	111	65.00
66.00	06600	PHYSICAL THERAPY	0	28,302	3,045	31,347	247	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,518	0	1,518	40	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,049	0	1,049	17	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	116	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	60	88.01
90.00	09000	CLINIC	0	29,709	0	29,709	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	20,483	286	20,769	488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,899	10,101	16,000	42	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	531,773	654,062	1,185,835	5,088	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,718	0	2,718	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37,282	14,397	51,679	976	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	6,011	11,094	17,105	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	577,784	679,553	1,257,337	6,064	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/2/2016 2:03 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	517,940					5.00
7.00	00700	OPERATION OF PLANT	12,994	98,168				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	14,375	0	14,375			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	341	0	0	341		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	4,289	2,843	440	0	22,127	8.00
9.00	00900	HOUSEKEEPING	15,414	515	80	0	1,292	9.00
10.00	01000	DIETARY	14,366	1,903	294	0	245	10.00
11.00	01100	CAFETERIA	4,788	2,233	345	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,753	645	100	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,371	734	114	0	0	14.00
15.00	01500	PHARMACY	10,740	1,221	189	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,696	4,357	674	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	40,841	10,743	1,662	0	3,996	30.00
31.00	03100	INTENSIVE CARE UNIT	4,851	1,263	195	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	53,557	25,207	3,901	0	10,889	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,816	7,026	1,087	0	957	50.00
53.00	05300	ANESTHESIOLOGY	71	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,218	5,544	858	0	352	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,010	0	0	0	0	55.00
60.00	06000	LABORATORY	38,687	2,198	340	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,952	3,664	567	0	2	65.00
66.00	06600	PHYSICAL THERAPY	15,810	6,253	967	0	973	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,408	335	52	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,138	232	36	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,324	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	426	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,562	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	8,836	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	4,358	0	0	0	0	88.01
90.00	09000	CLINIC	15,656	6,563	0	341	0	90.00
90.01	09002	WOUND CARE	4,079	0	0	0	0	90.01
91.00	09100	EMERGENCY	39,469	4,525	700	0	1,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,256	0	202	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	441,452	88,004	12,803	341	20,568	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	68	600	93	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	75,076	8,236	1,274	0	4	192.00
192.01	19201	FAYETTE COUNTY ANNEX	384	1,328	205	0	90	192.01
192.02	19202	PUBLIC RELATIONS	960	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	1,465	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)	517,940	98,168	14,375	341	22,127	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/2/2016 2:03 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	19,862					9.00
10.00	01000	DIETARY	393	29,619				10.00
11.00	01100	CAFETERIA	461	0	17,977			11.00
13.00	01300	NURSING ADMINISTRATION	133	0	853	13,546		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	152	0	292	0	8,017	14.00
15.00	01500	PHARMACY	252	0	351	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	900	0	729	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	2,220	5,584	2,428	5,015	0	30.00
31.00	03100	INTENSIVE CARE UNIT	261	127	296	611	0	31.00
44.00	04400	SKILLED NURSING FACILITY	5,212	22,195	4,737	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,452	0	893	1,845	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,146	0	1,089	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	454	0	1,509	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	757	0	478	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,292	0	809	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	69	0	91	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	48	0	51	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,289	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	728	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	880	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	371	0	88.01
90.00	09000	CLINIC	1,356	1,713	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	935	0	2,092	4,321	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	269	0	244	503	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,762	29,619	16,942	13,546	8,017	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	124	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,702	0	1,035	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	274	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)	19,862	29,619	17,977	13,546	8,017	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/2/2016 2:03 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	23,214					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,401				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,217		130,394	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	48		13,445	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	1,984		246,177	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,454		94,045	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		71	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,394		133,251	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	399		4,409	0	55.00
60.00	06000	LABORATORY	0	7,997		111,464	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,348		41,085	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,169		58,867	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	164		4,677	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	42		2,613	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,792		22,405	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	42		1,196	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,214	3,694		47,470	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	95		9,927	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	107		4,896	0	88.01
90.00	09000	CLINIC	0	1,294		56,632	0	90.00
90.01	09002	WOUND CARE	0	300		4,379	0	90.01
91.00	09100	EMERGENCY	0	4,511		79,672	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	866		22,382	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,214	37,917	0	1,089,457	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		3,603	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,484		142,466	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		19,386	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0		960	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0		1,465	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)	23,214	40,401	0	1,257,337	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/2/2016 2:03 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	130,394		30.00
31.00	03100	INTENSIVE CARE UNIT	13,445		31.00
44.00	04400	SKILLED NURSING FACILITY	246,177		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	94,045		50.00
53.00	05300	ANESTHESIOLOGY	71		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	133,251		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,409		55.00
60.00	06000	LABORATORY	111,464		60.00
65.00	06500	RESPIRATORY THERAPY	41,085		65.00
66.00	06600	PHYSICAL THERAPY	58,867		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,677		67.00
68.00	06800	SPEECH PATHOLOGY	2,613		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,405		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,196		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,470		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	9,927		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	4,896		88.01
90.00	09000	CLINIC	56,632		90.00
90.01	09002	WOUND CARE	4,379		90.01
91.00	09100	EMERGENCY	79,672		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	22,382		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,089,457		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,603		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	142,466		192.00
192.01	19201	FAYETTE COUNTY ANNEX	19,386		192.01
192.02	19202	PUBLIC RELATIONS	960		192.02
192.03	19203	PERSONAL LAUNDRY	1,465		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)	1,257,337		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/2/2016 2:03 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	103,524					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		679,553				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	900	1,041	10,025,572			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,441	464,848	661,879	-3,799,351	20,713,763	5.00
7.00	00700	OPERATION OF PLANT	12,509	15,206	252,949	0	519,662	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	574,884	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	13,637	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	1,638	76,983	0	171,538	8.00
9.00	00900	HOUSEKEEPING	418	0	376,899	0	616,454	9.00
10.00	01000	DIETARY	1,543	3,657	245,880	0	574,514	10.00
11.00	01100	CAFETERIA	1,811	0	70,561	0	191,467	11.00
13.00	01300	NURSING ADMINISTRATION	523	0	236,557	0	350,054	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	0	54,727	0	134,794	14.00
15.00	01500	PHARMACY	990	4,820	192,363	0	429,503	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,534	1,173	244,600	0	507,748	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	1,320,926	0	1,633,328	30.00
31.00	03100	INTENSIVE CARE UNIT	1,024	0	129,136	0	193,982	31.00
44.00	04400	SKILLED NURSING FACILITY	20,443	3,623	1,282,084	0	2,141,840	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,698	25,430	469,545	0	872,453	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,496	54,298	427,318	0	1,448,433	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	160,376	55.00
60.00	06000	LABORATORY	1,783	50,017	513,969	0	1,547,181	60.00
65.00	06500	RESPIRATORY THERAPY	2,972	8,619	184,093	0	358,008	65.00
66.00	06600	PHYSICAL THERAPY	5,071	3,045	408,702	0	632,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	272	0	66,021	0	96,297	67.00
68.00	06800	SPEECH PATHOLOGY	188	0	28,864	0	45,508	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	532,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	17,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	822,315	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	190,970	0	353,354	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	98,394	0	174,297	88.01
90.00	09000	CLINIC	5,323	0	0	0	626,102	90.00
90.01	09002	WOUND CARE	0	0	0	0	163,125	90.01
91.00	09100	EMERGENCY	3,670	286	805,868	0	1,578,446	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	70,013	0	170,216	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,280	654,062	8,409,301	-3,799,351	17,654,509	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	487	0	0	0	2,718	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,680	14,397	1,616,271	0	3,002,771	192.00
192.01	19201	FAYETTE COUNTY ANNEX	1,077	11,094	0	0	15,375	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	38,390	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)	577,784	679,553	3,583,355		3,799,351	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.581160	1.000000	0.357422		0.183422	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,064		517,940	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000605		0.025005	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/2/2016 2:03 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	79,617					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	75,351				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	407,672		8.00
9.00	00900	HOUSEKEEPING	418	418	0	23,796	77,950	9.00
10.00	01000	DIETARY	1,543	1,543	0	4,513	1,543	10.00
11.00	01100	CAFETERIA	1,811	1,811	0	0	1,811	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	73,615	8,713	30.00
31.00	03100	INTENSIVE CARE UNIT	1,024	1,024	0	5	1,024	31.00
44.00	04400	SKILLED NURSING FACILITY	20,443	20,443	0	200,625	20,443	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,698	5,698	0	17,626	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	6,490	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	45	2,972	65.00
66.00	06600	PHYSICAL THERAPY	5,071	5,071	0	17,926	5,071	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	34,305	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)	71,373	67,107	5,323	378,946	69,706	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	70	6,680	192.00
192.01	19201	FAYETTE COUNTY ANNEX	1,077	1,077	0	1,656	1,077	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	27,000	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)	614,979	680,330	16,138	241,634	750,632	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.724217	9.028812	3.031749	0.592717	9.629660	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,168	14,375	341	22,127	19,862	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.233003	0.190774	0.064062	0.054276	0.254804	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/2/2016 2:03 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	54,733					10.00
11.00	01100	CAFETERIA	0	13,424				11.00
13.00	01300	NURSING ADMINISTRATION	0	637	4,897			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	218	0	549,912		14.00
15.00	01500	PHARMACY	0	262	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	544	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,319	1,813	1,813	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	234	221	221	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	41,014	3,538	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	667	667	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	813	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	1,127	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	357	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	604	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	68	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	38	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	499,977	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	49,935	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	318	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	134	0	0	88.01
90.00	09000	CLINIC	3,166	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	1,562	1,562	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	182	182	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,733	12,651	4,897	549,912	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	773	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)	723,276	274,365	441,079	179,672	539,757	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.214624	20.438394	90.071268	0.326729	5,397.570000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,619	17,977	13,546	8,017	23,214	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.541154	1.339169	2.766183	0.014579	232.140000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/2/2016 2:03 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	65,089,125			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,569,561	0		30.00
31.00	03100	INTENSIVE CARE UNIT	77,174	0		31.00
44.00	04400	SKILLED NURSING FACILITY	3,195,048	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,341,995	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,549,452	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	642,764	0		55.00
60.00	06000	LABORATORY	12,876,971	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,170,172	0		65.00
66.00	06600	PHYSICAL THERAPY	1,883,072	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	263,355	0		67.00
68.00	06800	SPEECH PATHOLOGY	67,986	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,884,916	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	67,389	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,949,171	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	153,570	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	171,874	0		88.01
90.00	09000	CLINIC	2,084,053	0		90.00
90.01	09002	WOUND CARE	482,574	0		90.01
91.00	09100	EMERGENCY	7,263,952	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,394,853	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,089,902	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,999,223	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)	705,234	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010835	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,401	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000621	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/2/2016 2:03 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	2,581,812		2,581,812	0	2,581,812	30.00
31.00	03100	INTENSIVE CARE UNIT	284,934		284,934	0	284,934	31.00
44.00	04400	SKILLED NURSING FACILITY	3,841,869		3,841,869	0	3,841,869	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,292,342		1,292,342	0	1,292,342	50.00
53.00	05300	ANESTHESIOLOGY	3,337		3,337	0	3,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,999,989		1,999,989	0	1,999,989	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	196,756		196,756	0	196,756	55.00
60.00	06000	LABORATORY	2,040,564		2,040,564	0	2,040,564	60.00
65.00	06500	RESPIRATORY THERAPY	532,922	0	532,922	0	532,922	65.00
66.00	06600	PHYSICAL THERAPY	925,392	0	925,392	0	925,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,379	0	125,379	0	125,379	67.00
68.00	06800	SPEECH PATHOLOGY	60,328	0	60,328	0	60,328	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	825,220		825,220	0	825,220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,218		37,218	0	37,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,577,362		1,577,362	0	1,577,362	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	448,474		448,474	0	448,474	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	220,199		220,199	0	220,199	88.01
90.00	09000	CLINIC	913,874		913,874	0	913,874	90.00
90.01	09002	WOUND CARE	198,275		198,275	0	198,275	90.01
91.00	09100	EMERGENCY	2,236,447		2,236,447	0	2,236,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	406,041		406,041		406,041	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	256,385		256,385	0	256,385	95.00
200.00		Subtotal (see instructions)	21,005,119	0	21,005,119	0	21,005,119	200.00
201.00		Less Observation Beds	406,041		406,041		406,041	201.00
202.00		Total (see instructions)	20,599,078	0	20,599,078	0	20,599,078	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/2/2016 2:03 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	2,311,186		2,311,186			30.00
31.00	03100	INTENSIVE CARE UNIT	107,174		107,174			31.00
44.00	04400	SKILLED NURSING FACILITY	3,195,048		3,195,048			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,611	2,228,383	2,341,994	0.551813	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	518,621	13,030,831	13,549,452	0.147607	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	50,123	592,641	642,764	0.306109	0.000000	55.00
60.00	06000	LABORATORY	1,159,066	11,717,906	12,876,972	0.158466	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	791,663	1,378,509	2,170,172	0.245567	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	332,496	1,550,577	1,883,073	0.491427	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,232	191,123	263,355	0.476084	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	17,780	50,206	67,986	0.887359	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,879,473	1,005,443	2,884,916	0.286046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,779	64,610	67,389	0.552286	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,235,277	3,713,894	5,949,171	0.265140	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	153,569	153,569			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	171,874	171,874			88.01
90.00	09000	CLINIC	0	2,084,053	2,084,053	0.438508	0.000000	90.00
90.01	09002	WOUND CARE	355	482,219	482,574	0.410870	0.000000	90.01
91.00	09100	EMERGENCY	55,841	7,208,111	7,263,952	0.307883	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	68,557	1,174,818	1,243,375	0.326564	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,958	1,391,894	1,394,852	0.183808	0.000000	95.00
200.00		Subtotal (see instructions)	12,914,240	48,190,661	61,104,901			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,914,240	48,190,661	61,104,901			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/2/2016 2:03 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	2,581,812		2,581,812	0	2,581,812	30.00
31.00	03100	INTENSIVE CARE UNIT	284,934		284,934	0	284,934	31.00
44.00	04400	SKILLED NURSING FACILITY	3,841,869		3,841,869	0	3,841,869	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,292,342		1,292,342	0	1,292,342	50.00
53.00	05300	ANESTHESIOLOGY	3,337		3,337	0	3,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,999,989		1,999,989	0	1,999,989	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	196,756		196,756	0	196,756	55.00
60.00	06000	LABORATORY	2,040,564		2,040,564	0	2,040,564	60.00
65.00	06500	RESPIRATORY THERAPY	532,922	0	532,922	0	532,922	65.00
66.00	06600	PHYSICAL THERAPY	925,392	0	925,392	0	925,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,379	0	125,379	0	125,379	67.00
68.00	06800	SPEECH PATHOLOGY	60,328	0	60,328	0	60,328	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	825,220		825,220	0	825,220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,218		37,218	0	37,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,577,362		1,577,362	0	1,577,362	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	448,474		448,474	0	448,474	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	220,199		220,199	0	220,199	88.01
90.00	09000	CLINIC	913,874		913,874	0	913,874	90.00
90.01	09002	WOUND CARE	198,275		198,275	0	198,275	90.01
91.00	09100	EMERGENCY	2,236,447		2,236,447	0	2,236,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	406,041		406,041		406,041	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	256,385		256,385	0	256,385	95.00
200.00		Subtotal (see instructions)	21,005,119	0	21,005,119	0	21,005,119	200.00
201.00		Less Observation Beds	406,041		406,041		406,041	201.00
202.00		Total (see instructions)	20,599,078	0	20,599,078	0	20,599,078	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/2/2016 2:03 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	2,311,186		2,311,186			30.00
31.00	03100	INTENSIVE CARE UNIT	107,174		107,174			31.00
44.00	04400	SKILLED NURSING FACILITY	3,195,048		3,195,048			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,611	2,228,383	2,341,994	0.551813	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	518,621	13,030,831	13,549,452	0.147607	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	50,123	592,641	642,764	0.306109	0.000000	55.00
60.00	06000	LABORATORY	1,159,066	11,717,906	12,876,972	0.158466	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	791,663	1,378,509	2,170,172	0.245567	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	332,496	1,550,577	1,883,073	0.491427	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,232	191,123	263,355	0.476084	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	17,780	50,206	67,986	0.887359	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,879,473	1,005,443	2,884,916	0.286046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,779	64,610	67,389	0.552286	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,235,277	3,713,894	5,949,171	0.265140	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	153,569	153,569	2.920342	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	171,874	171,874	1.281165	0.000000	88.01
90.00	09000	CLINIC	0	2,084,053	2,084,053	0.438508	0.000000	90.00
90.01	09002	WOUND CARE	355	482,219	482,574	0.410870	0.000000	90.01
91.00	09100	EMERGENCY	55,841	7,208,111	7,263,952	0.307883	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	68,557	1,174,818	1,243,375	0.326564	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,958	1,391,894	1,394,852	0.183808	0.000000	95.00
200.00		Subtotal (see instructions)	12,914,240	48,190,661	61,104,901			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,914,240	48,190,661	61,104,901			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/2/2016 2:03 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	94,045	2,341,994	0.040156	68,068	2,733	50.00
53.00	05300	ANESTHESIOLOGY	71	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	133,251	13,549,452	0.009834	121,776	1,198	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,409	642,764	0.006859	23,878	164	55.00
60.00	06000	LABORATORY	111,464	12,876,972	0.008656	568,019	4,917	60.00
65.00	06500	RESPIRATORY THERAPY	41,085	2,170,172	0.018932	349,132	6,610	65.00
66.00	06600	PHYSICAL THERAPY	58,867	1,883,073	0.031261	72,326	2,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,677	263,355	0.017759	9,895	176	67.00
68.00	06800	SPEECH PATHOLOGY	2,613	67,986	0.038434	4,341	167	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,405	2,884,916	0.007766	974,870	7,571	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,196	67,389	0.017748	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,470	5,949,171	0.007979	870,717	6,947	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	9,927	153,569	0.064642	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	4,896	171,874	0.028486	0	0	88.01
90.00	09000	CLINIC	56,632	2,084,053	0.027174	0	0	90.00
90.01	09002	WOUND CARE	4,379	482,574	0.009074	0	0	90.01
91.00	09100	EMERGENCY	79,672	7,263,952	0.010968	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	31,098	1,243,375	0.025011	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	708,157	54,096,641		3,063,022	32,744	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/2/2016 2:03 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	2,341,994	0.000000	0.000000	68,068	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,549,452	0.000000	0.000000	121,776	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	642,764	0.000000	0.000000	23,878	55.00
60.00	06000	LABORATORY	0	12,876,972	0.000000	0.000000	568,019	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,170,172	0.000000	0.000000	349,132	65.00
66.00	06600	PHYSICAL THERAPY	0	1,883,073	0.000000	0.000000	72,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	263,355	0.000000	0.000000	9,895	67.00
68.00	06800	SPEECH PATHOLOGY	0	67,986	0.000000	0.000000	4,341	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,884,916	0.000000	0.000000	974,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	67,389	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,949,171	0.000000	0.000000	870,717	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	153,569	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	171,874	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	2,084,053	0.000000	0.000000	0	90.00
90.01	09002	WOUND CARE	0	482,574	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	7,263,952	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,243,375	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	54,096,641			3,063,022	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/2/2016 2:03 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	0.551813	0	917,593	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147607	0	4,619,972	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.306109	0	358,300	0	0	55.00
60.00	06000	LABORATORY	0.158466	0	5,438,017	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.245567	0	885,913	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.491427	0	599,806	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476084	0	45,542	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.887359	0	13,708	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.286046	0	368,341	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.552286	0	45,351	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265140	0	2,463,156	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	0.438508	0	1,974,766	0	0	90.00
90.01	09002	WOUND CARE	0.410870	0	286,575	0	0	90.01
91.00	09100	EMERGENCY	0.307883	0	1,806,820	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.326564	0	223,652	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.183808		0			95.00
200.00		Subtotal (see instructions)		0	20,047,512	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	20,047,512	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/2/2016 2:03 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	506,340	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	681,940	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	109,679	0	55.00
60.00	06000	LABORATORY	861,741	0	60.00
65.00	06500	RESPIRATORY THERAPY	217,551	0	65.00
66.00	06600	PHYSICAL THERAPY	294,761	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,682	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,164	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,362	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	25,047	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	653,081	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	865,951	0	90.00
90.01	09002	WOUND CARE	117,745	0	90.01
91.00	09100	EMERGENCY	556,289	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	73,037	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,102,370	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,102,370	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/2/2016 2:03 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	0.551813	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147607	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.306109	0	0	0	0	55.00
60.00	06000	LABORATORY	0.158466	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.245567	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.491427	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476084	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.887359	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.286046	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.552286	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265140	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	0.438508	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.410870	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.307883	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.326564	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.183808		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 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/2/2016 2:03 pm

Component CCN: 14Z346 | 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 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/2/2016 2:03 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	2,341,994	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	13,549,452	0.000000	0.000000	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	642,764	0.000000	0.000000	0	55.00
60.00	06000	LABORATORY	0	12,876,972	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,170,172	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,883,073	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	263,355	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	67,986	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,884,916	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	67,389	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,949,171	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	153,569	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	171,874	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	2,084,053	0.000000	0.000000	0	90.00
90.01	09002	WOUND CARE	0	482,574	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	7,263,952	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,243,375	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	54,096,641			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/2/2016 2:03 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	0.551813	0	294,647	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147607	0	3,942,825	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.306109	0	112,957	0	0	55.00
60.00	06000	LABORATORY	0.158466	0	2,449,466	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.245567	0	154,405	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.491427	0	220,679	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476084	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.887359	0	2,931	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.286046	0	202,106	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.552286	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265140	0	1,047,378	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	2.920342				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	1.281165				0	88.01
90.00	09000	CLINIC	0.438508	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.410870	0	26,167	0	0	90.01
91.00	09100	EMERGENCY	0.307883	0	2,796,423	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.326564	0	236,077	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.183808	0	290,642			95.00
200.00		Subtotal (see instructions)		0	11,776,703	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	11,776,703	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/2/2016 2:03 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	162,590	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	581,989	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	34,577	0		55.00
60.00	06000	LABORATORY	388,157	0		60.00
65.00	06500	RESPIRATORY THERAPY	37,917	0		65.00
66.00	06600	PHYSICAL THERAPY	108,448	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,601	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,812	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	277,702	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	10,751	0		90.01
91.00	09100	EMERGENCY	860,971	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	77,094	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	53,422			95.00
200.00		Subtotal (see instructions)	2,654,031	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,654,031	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/2/2016 2:03 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)	3,235	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,042	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)	1,555	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,020	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	173	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)	928	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)	1,020	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)	2,581,812	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)	28,856	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)	879,281	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,702,531	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)	1,702,531	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)	833.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	773,720	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)	773,720	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/2/2016 2:03 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	284,934	92	3,097.11	92	284,934	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)	792,418	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,851,072	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)	850,425	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)	850,425	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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)	487	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	833.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	406,041	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/2/2016 2:03 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	130,394	1,702,531	0.076588	406,041	31,098	90.00
91.00	Nursing School cost	0	1,702,531	0.000000	406,041	0	91.00
92.00	Allied health cost	0	1,702,531	0.000000	406,041	0	92.00
93.00	All other Medical Education	0	1,702,531	0.000000	406,041	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141346 Component CCN: 145499	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/2/2016 2:03 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)	17,573	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,573	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)	17,573	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)	0	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)	3,841,869	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)	3,841,869	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)	3,841,869	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 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/2/2016 2:03 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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,841,869	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	218.62	71.00
72.00	Program routine service cost (line 9 x line 71)	0	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)	0	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)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	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)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 145499 | Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/2/2016 2:03 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)	3,235	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,042	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)	1,555	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,020	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	173	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)	212	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	173	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)	2,581,812	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)	28,856	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)	879,281	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,702,531	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)	1,702,531	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)	833.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	176,755	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)	176,755	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/2/2016 2:03 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	284,934	92	3,097.11	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)	129,254	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	306,009	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)	28,856	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)	28,856	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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)	487	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	833.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	406,041	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/2/2016 2:03 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	130,394	1,702,531	0.076588	406,041	31,098	90.00
91.00	Nursing School cost	0	1,702,531	0.000000	406,041	0	91.00
92.00	Allied health cost	0	1,702,531	0.000000	406,041	0	92.00
93.00	All other Medical Education	0	1,702,531	0.000000	406,041	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/2/2016 2:03 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		959,532		30.00
31.00	03100	INTENSIVE CARE UNIT		83,742		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.551813	68,068	37,561	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147607	121,776	17,975	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.306109	23,878	7,309	55.00
60.00	06000	LABORATORY	0.158466	568,019	90,012	60.00
65.00	06500	RESPIRATORY THERAPY	0.245567	349,132	85,735	65.00
66.00	06600	PHYSICAL THERAPY	0.491427	72,326	35,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476084	9,895	4,711	67.00
68.00	06800	SPEECH PATHOLOGY	0.887359	4,341	3,852	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.286046	974,870	278,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.552286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265140	870,717	230,862	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	0.438508	0	0	90.00
90.01	09002	WOUND CARE	0.410870	0	0	90.01
91.00	09100	EMERGENCY	0.307883	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.326564	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)		3,063,022	792,418	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)		3,063,022		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/2/2016 2:03 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	0.551813	2,130	1,175	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147607	50,583	7,466	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.306109	5,895	1,805	55.00
60.00	06000	LABORATORY	0.158466	199,409	31,600	60.00
65.00	06500	RESPIRATORY THERAPY	0.245567	172,901	42,459	65.00
66.00	06600	PHYSICAL THERAPY	0.491427	178,118	87,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476084	40,726	19,389	67.00
68.00	06800	SPEECH PATHOLOGY	0.887359	9,441	8,378	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.286046	250,277	71,591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.552286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265140	663,393	175,892	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	0.438508	0	0	90.00
90.01	09002	WOUND CARE	0.410870	355	146	90.01
91.00	09100	EMERGENCY	0.307883	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.326564	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)		1,573,228	447,433	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)		1,573,228		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3

Component CCN: 145499 | Date/Time Prepared: 5/2/2016 2:03 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	0.551813	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147607	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.306109	0	0	55.00
60.00	06000	LABORATORY	0.158466	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.245567	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.491427	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476084	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.887359	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.286046	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.552286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265140	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	0.438508	0	0	90.00
90.01	09002	WOUND CARE	0.410870	0	0	90.01
91.00	09100	EMERGENCY	0.307883	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.326564	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/2/2016 2:03 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		289,645		30.00
31.00	03100	INTENSIVE CARE UNIT		22,988		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.551813	8,826	4,870	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147607	59,108	8,725	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.306109	3,801	1,164	55.00
60.00	06000	LABORATORY	0.158466	110,440	17,501	60.00
65.00	06500	RESPIRATORY THERAPY	0.245567	111,661	27,420	65.00
66.00	06600	PHYSICAL THERAPY	0.491427	5,022	2,468	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.476084	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.887359	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.286046	61,178	17,500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.552286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.265140	181,276	48,064	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	2.920342	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	1.281165	0	0	88.01
90.00	09000	CLINIC	0.438508	0	0	90.00
90.01	09002	WOUND CARE	0.410870	0	0	90.01
91.00	09100	EMERGENCY	0.307883	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.326564	4,723	1,542	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		546,035	129,254	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)		546,035		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/2/2016 2:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,102,370	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)	5,102,370	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, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,153,394	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)	32,055	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,919,080	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] (see instructions)	2,202,259	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)	2,202,259	30.00
31.00	Primary payer payments	73	31.00
32.00	Subtotal (line 30 minus line 31)	2,202,186	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)	491,551	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	319,508	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	469,672	36.00
37.00	Subtotal (see instructions)	2,521,694	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)	2,521,694	40.00
40.01	Sequestration adjustment (see instructions)	50,434	40.01
41.00	Interim payments	2,644,435	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-173,175	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 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/2/2016 2:03 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		1,346,254		2,644,435	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	02/19/2015	102,876		0	3.01
3.02		07/24/2015	46,400		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)		149,276		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)		1,495,530		2,644,435	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		99,654		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		173,175	6.02
7.00	Total Medicare program liability (see instructions)		1,595,184		2,471,260	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 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/2/2016 2:03 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		977,978		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/24/2015	71,800		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)		71,800		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)		1,049,778		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		215,702		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,265,480		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141346	Period:	Worksheet E-1
Component CCN: 145499	From 01/01/2015 To 12/31/2015	Part I Date/Time Prepared: 5/2/2016 2:03 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		0		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)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/2/2016 2:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD 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	524	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,020	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	30	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,647	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	61,104,901	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	158,328	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141346 Component CCN: 14Z346	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/2/2016 2:03 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)	858,929	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 Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	451,907	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	1,020	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)	1,310,836	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,310,836	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)	1,310,836	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,530	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)	1,291,306	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)	1,291,306	0	19.00
19.01	Sequestration adjustment (see instructions)	25,826	0	19.01
20.00	Interim payments	1,049,778	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)	215,702	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/2/2016 2:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,851,072	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)	1,851,072	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,869,583	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)	1,869,583	19.00
20.00	Deductibles (exclude professional component)	273,244	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,596,339	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,596,339	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	48,307	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	31,400	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,274	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,627,739	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)	1,627,739	30.00
30.01	Sequestration adjustment (see instructions)	32,555	30.01
31.00	Interim payments	1,495,530	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)	99,654	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 01/01/2015 To 12/31/2015	Worksheet E-3 Part VI Date/Time Prepared: 5/2/2016 2:03 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)	0	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)	0	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	0	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	0	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	0	15.00
15.01	Sequestration adjustment (see instructions)	0	15.01
16.00	Interim payments	0	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)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/2/2016 2:03 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	306,009		1.00
2.00	Medical and other services		2,654,031	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	306,009	2,654,031	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)	306,009	2,654,031	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	546,035	11,776,703	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)	546,035	11,776,703	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)	546,035	11,776,703	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	240,026	9,122,672	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)	306,009	2,654,031	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)	306,009	2,654,031	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)	306,009	2,654,031	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)	306,009	2,654,031	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	306,009	2,654,031	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)	306,009	2,654,031	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	306,009	2,654,031	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 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/2/2016 2:03 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 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/2/2016 2:03 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	610,475	0	0	0	1.00
2.00	Temporary investments	3,625,477	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,107,254	0	0	0	4.00
5.00	Other receivable	1,071,598	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,409,047	0	0	0	6.00
7.00	Inventory	462,936	0	0	0	7.00
8.00	Prepaid expenses	376,041	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	16,667	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,861,401	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	33,453,136	0	0	0	19.00
20.00	Accumulated depreciation	-20,868,784	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)	12,584,352	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	4,423	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,423	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,450,176	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	722,557	0	0	0	37.00
38.00	Salaries, wages, and fees payable	715,712	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	2,002,157	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,440,426	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,173,412	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	2,173,412	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	5,613,838	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	17,836,338				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)	17,836,338	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,450,176	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/2/2016 2:03 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,509,535		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		326,797				2.00
3.00	Total (sum of line 1 and line 2)		17,836,332		0		3.00
4.00	Additions	6		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)		6		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,836,338		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,836,338		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		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			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 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/2/2016 2:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,069,081		3,069,081	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	7,320		7,320	6.00
7.00	SKILLED NURSING FACILITY	3,187,728		3,187,728	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)	6,264,129		6,264,129	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	77,174		77,174	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)	77,174		77,174	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,341,303		6,341,303	17.00
18.00	Ancillary services	7,370,760	47,675,619	55,046,379	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC (RHC) VANDALIA	0	153,663	153,663	20.00
20.01	RURAL HEALTH CLINIC (RHC) ST ELMO	0	171,874	171,874	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	1,391,894	1,391,894	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	127,416	2,441,187	2,568,603	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,839,479	51,834,237	65,673,716	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,081,763		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	153,990			37.00
38.00	PHYSICIAN EXPENSE	2,621,466			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)		2,775,456		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,306,307		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141346	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/2/2016 2:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,673,716	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,331,642	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,342,074	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,306,307	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-964,233	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	257,378	24.00
25.00	Total other income (sum of lines 6-24)	257,378	25.00
26.00	Total (line 5 plus line 25)	-706,855	26.00
27.00	OTHER EXPENSES	-1,033,652	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-1,033,652	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	326,797	29.00

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

Provider CCN: 141346 | Component CCN: 148527 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/2/2016 2:03 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	37,015	0	37,015	0	37,015	1.00
2.00	Physician Assistant	63,020	0	63,020	0	63,020	2.00
3.00	Nurse Practitioner	709	0	709	0	709	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	90,226	0	90,226	-61	90,165	9.00
10.00	Subtotal (sum of lines 1 through 9)	190,970	0	190,970	-61	190,909	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	94,188	94,188	0	94,188	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	94,188	94,188	0	94,188	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	190,970	94,188	285,158	-61	285,097	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)	190,970	94,188	285,158	-61	285,097	32.00

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

Provider CCN: 141346 | Component CCN: 148527 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/2/2016 2:03 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	37,015		1.00
2.00	Physician Assistant	0	63,020		2.00
3.00	Nurse Practitioner	0	709		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	90,165		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	190,909		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	94,188		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	94,188		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	285,097		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)	0	285,097		32.00

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

Provider CCN: 141346 Component CCN: 148528 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/2/2016 2:03 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	0	0	0	0	0	1.00
2.00	Physician Assistant	61,609	0	61,609	0	61,609	2.00
3.00	Nurse Practitioner	355	0	355	0	355	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	36,430	0	36,430	-1,263	35,167	9.00
10.00	Subtotal (sum of lines 1 through 9)	98,394	0	98,394	-1,263	97,131	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	41,998	41,998	0	41,998	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,998	41,998	0	41,998	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	98,394	41,998	140,392	-1,263	139,129	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)	98,394	41,998	140,392	-1,263	139,129	32.00

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

Provider CCN: 141346 | Component CCN: 148528 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/2/2016 2:03 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	0		1.00
2.00	Physician Assistant	0	61,609		2.00
3.00	Nurse Practitioner	0	355		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	35,167		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	97,131		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	41,998		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,998		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	139,129		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)	0	139,129		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141346 | Component CCN: 148527 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2 | Date/Time Prepared: 5/2/2016 2:03 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	0.14	297	4,200	588		1.00
2.00	Physician Assistant	0.45	1,394	2,100	945		2.00
3.00	Nurse Practitioner	0.01	21	2,100	21		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.60	1,712		1,554	1,712	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)	0.60	1,712			1,712	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)					285,097	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)					285,097	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)					163,377	15.00
16.00	Total overhead (sum of lines 14 and 15)					163,377	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					163,377	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					163,377	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					448,474	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141346 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2

Component CCN: 148528 | Date/Time Prepared: 5/2/2016 2:03 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	0.00	1	4,200	0		1.00
2.00	Physician Assistant	0.45	1,596	2,100	945		2.00
3.00	Nurse Practitioner	0.00	18	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.45	1,615		945	1,615	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)	0.45	1,615			1,615	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)					139,129	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)					139,129	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)					81,070	15.00
16.00	Total overhead (sum of lines 14 and 15)					81,070	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					81,070	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					81,070	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					220,199	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141346 | Component CCN: 148527 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-3 | Date/Time Prepared: 5/2/2016 2:03 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)		448,474	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)		448,474	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,712	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)		1,712	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		261.96	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)	80.44	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	261.96	261.96	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	619	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	162,153	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) *		162,153	16.00
16.01	Total program charges (see instructions)(from contractor's records)		83,788	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		123,534	16.04
16.05	Total program cost (see instructions)		123,534	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,735	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,210	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		123,534	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)		123,534	22.00
23.00	Allowable bad debts (see instructions)		3,379	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		2,196	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,379	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)		125,730	26.00
26.01	Sequestration adjustment (see instructions)		2,515	26.01
27.00	Interim payments		45,980	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)		77,235	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 01/01/2015 To 12/31/2015 | Worksheet M-3 | Date/Time Prepared: 5/2/2016 2:03 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)		220,199	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)		220,199	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,615	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)		1,615	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		136.35	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)	80.44	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	136.35	136.35	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	339	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	46,223	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) *		46,223	16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,539	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.)		33,311	16.04
16.05	Total program cost (see instructions)		33,311	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,584	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,790	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		33,311	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)		33,311	22.00
23.00	Allowable bad debts (see instructions)		1,453	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		944	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,453	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)		34,255	26.00
26.01	Sequestration adjustment (see instructions)		685	26.01
27.00	Interim payments		24,749	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)		8,821	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 01/01/2015 To 12/31/2015 | Worksheet M-5 | Date/Time Prepared: 5/2/2016 2:03 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		45,980	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		45,980	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		77,235	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		123,215	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 01/01/2015 To 12/31/2015 | Worksheet M-5 | Date/Time Prepared: 5/2/2016 2:03 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		24,749	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			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)		24,749	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		8,821	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		33,570	7.00

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