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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1346	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/23/2017 11:14 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/23/2017 Time: 11:14 am
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 (14-1346) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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	51,995	209,690	0	3,361,983	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	48,655	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		-39,024		0	10.00
10.01	RURAL HEALTH CLINIC (RHC) ST ELMO II	0		15,702		0	10.01
200.00	Total	0	100,650	186,368	0	3,361,983	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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2017 11:12 am

	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)	01/01/2016	12/31/2016	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 §412.106(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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 11:12 am

		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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 11:12 am

		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
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 11:12 am

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

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		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	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1346	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 11:12 am

		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)	01/01/2016	12/31/2016	170.00
		1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2017 11:12 am

		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		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	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)	Y	04/10/2017	Y	04/10/2017	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2017 11:12 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
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
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
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: 14-1346	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/23/2017 11:12 am

		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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2017 11:12 am

	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	7,686	24,456.00	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	7,686	24,456.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	1,608.00	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	9,150	26,064.00	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	31,110		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	89.00				0	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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2017 11:12 am

	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)	709	128	1,019			1.00
2.00	HMO and other (see instructions)	0	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	547	0	547			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		113	113			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,256	241	1,679			7.00
8.00	INTENSIVE CARE UNIT	71	0	71			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)	1,327	241	1,750	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	215	9,650	17,521	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	737	0	2,294	0.00	3.18	26.00
26.01	RURAL HEALTH CLINIC (RHC) ST ELMO	334	0	1,375	0.00	1.34	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	198.58	27.00
28.00	Observation Bed Days		0	641			28.00
29.00	Ambulance Trips	457					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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2017 11:12 am

	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	255	50	372	1.00
2.00	HMO and other (see instructions)			0	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	255	50	372	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	0.00					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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/23/2017 11:12 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	95,701	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)	3,282,833	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	53,160	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	16,610	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	37,880	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	200,620	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	630,983	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	73,981	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	21,181	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,412,949	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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-7 | Date/Time Prepared: 5/23/2017 11:12 am

		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	30	0	30	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	20	0	20	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	46	0	46	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	14	0	14	15.00
16.00		RVB	27	0	27	16.00
17.00		RVA	8	0	8	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	22	0	22	20.00
21.00		RMC	22	0	22	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	8	0	8	23.00
24.00		RLB	4	0	4	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	3	0	3	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	11	0	11	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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-7 | Date/Time Prepared: 5/23/2017 11:12 am

		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		215	0	215	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)	3,355,387			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1346 | Component CCN: 14-8527 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-8 | Date/Time Prepared: 5/23/2017 11:12 am

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	HOSPITAL-BASED 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)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	17:00	07:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC 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	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1346
Component CCN: 14-8527

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-8
Date/Time Prepared:
5/23/2017 11:12 am

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 RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1346 | Component CCN: 14-8528 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-8 | Date/Time Prepared: 5/23/2017 11:12 am

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	HOSPITAL-BASED 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)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based 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	12:00	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	RHC/FQHC 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	12:00	13:00	17:00	08:00	12:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1346
Component CCN: 14-8528

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-8
Date/Time Prepared:
5/23/2017 11:12 am

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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/23/2017 11:12 am

		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)	0.336543	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,126,506	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	2,591,336	5.00
6.00	Medicaid charges	19,356,771	6.00
7.00	Medicaid cost (line 1 times line 6)	6,514,386	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	126,896	0	126,896	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	42,706	0	42,706	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)	42,706	0	42,706	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)	2,781,422	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	682,210	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,099,212	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	706,475	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	749,181	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	749,181	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/23/2017 11:12 am

		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		1,770,751	1,770,751	-588,509	1,182,242	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	644,870	644,870	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	77,635	3,947,181	4,024,816	4,097	4,028,913	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	884,408	2,855,052	3,739,460	133,256	3,872,716	5.00
7.00	00700	OPERATION OF PLANT	253,718	66,896	320,614	23,901	344,515	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	601,486	601,486	0	601,486	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	12,615	12,615	0	12,615	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	80,420	44,752	125,172	0	125,172	8.00
9.00	00900	HOUSEKEEPING	392,714	105,809	498,523	0	498,523	9.00
10.00	01000	DIETARY	315,779	382,907	698,686	-186,437	512,249	10.00
11.00	01100	CAFETERIA	0	0	0	186,437	186,437	11.00
13.00	01300	NURSING ADMINISTRATION	168,174	19,023	187,197	0	187,197	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,885	84,544	139,429	0	139,429	14.00
15.00	01500	PHARMACY	192,462	166,009	358,471	0	358,471	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	227,347	162,749	390,096	0	390,096	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	292,483	292,483	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	920,009	192,048	1,112,057	-138,630	973,427	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	109,302	109,302	31.00
44.00	04400	SKILLED NURSING FACILITY	1,340,407	455,311	1,795,718	-38,750	1,756,968	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	543,824	625,396	1,169,220	-376,794	792,426	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	435,428	901,127	1,336,555	-2,729	1,333,826	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	144,409	144,409	-3,747	140,662	55.00
60.00	06000	LABORATORY	551,113	857,619	1,408,732	-1,955	1,406,777	60.00
65.00	06500	RESPIRATORY THERAPY	149,861	109,203	259,064	-23,870	235,194	65.00
66.00	06600	PHYSICAL THERAPY	398,275	40,936	439,211	-168	439,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,471	4,606	68,077	0	68,077	67.00
68.00	06800	SPEECH PATHOLOGY	29,710	4,148	33,858	0	33,858	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	401,534	401,534	48,524	450,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	151,311	151,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,100,599	1,100,599	47,890	1,148,489	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	424,646	90,925	515,571	184	515,755	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	155,482	71,235	226,717	0	226,717	88.01
90.00	09000	CLINIC	0	601,403	601,403	-3	601,400	90.00
90.01	09002	WOUND CARE	60,473	249,278	309,751	0	309,751	90.01
90.02	09003	PAIN MANAGEMENT	0	107,500	107,500	0	107,500	90.02
90.03	09001	NEUROLOGY	145,915	3,059	148,974	0	148,974	90.03
90.04	09004	DR SKOW	0	0	0	54,888	54,888	90.04
90.05	09005	DR BLASER	0	0	0	52,572	52,572	90.05
91.00	09100	EMERGENCY	972,875	1,572,757	2,545,632	247,099	2,792,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	372,898	65,994	438,892	-306,911	131,981	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,211,929	17,818,861	27,030,790	328,311	27,359,101	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	1,850,914	419,599	2,270,513	-114,740	2,155,773	192.00
192.01	19201	FAYETTE COUNTY ANNEX	83,670	129,848	213,518	-213,571	-53	192.01
192.02	19202	PUBLIC RELATIONS	0	42,108	42,108	0	42,108	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)	11,146,513	18,410,416	29,556,929	0	29,556,929	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/23/2017 11:12 am

		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	-379,622	802,620		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	644,870		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-664	4,028,249		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-120,836	3,751,880		5.00
7.00	00700	OPERATION OF PLANT	-1,742	342,773		7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	601,486		7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	12,615		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,172		8.00
9.00	00900	HOUSEKEEPING	0	498,523		9.00
10.00	01000	DIETARY	-78,366	433,883		10.00
11.00	01100	CAFETERIA	0	186,437		11.00
13.00	01300	NURSING ADMINISTRATION	0	187,197		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	139,429		14.00
15.00	01500	PHARMACY	0	358,471		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,959	375,137		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-292,483	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-130,693	842,734		30.00
31.00	03100	INTENSIVE CARE UNIT	0	109,302		31.00
44.00	04400	SKILLED NURSING FACILITY	-151,994	1,604,974		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	792,426		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,651	1,335,477		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	140,662		55.00
60.00	06000	LABORATORY	0	1,406,777		60.00
65.00	06500	RESPIRATORY THERAPY	0	235,194		65.00
66.00	06600	PHYSICAL THERAPY	0	439,043		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	68,077		67.00
68.00	06800	SPEECH PATHOLOGY	0	33,858		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	450,058		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	151,311		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-128,619	1,019,870		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	515,755		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	226,717		88.01
90.00	09000	CLINIC	0	601,400		90.00
90.01	09002	WOUND CARE	-246,075	63,676		90.01
90.02	09003	PAIN MANAGEMENT	-107,500	0		90.02
90.03	09001	NEUROLOGY	-132,137	16,837		90.03
90.04	09004	DR SKOW	-39,212	15,676		90.04
90.05	09005	DR BLASER	-43,865	8,707		90.05
91.00	09100	EMERGENCY	-1,189,061	1,603,670		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	131,981		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,056,177	24,302,924		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,155,773		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	-53		192.01
192.02	19202	PUBLIC RELATIONS	0	42,108		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)	-3,056,177	26,500,752		200.00

RECLASSIFICATIONS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 11:12 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	84,262	102,175		1.00
	TOTALS		84,262	102,175		
	B - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	292,483		1.00
	TOTALS		0	292,483		
	D - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	644,870		1.00
	TOTALS		0	644,870		
	E - ER					
1.00	EMERGENCY	91.00	300,744	0		1.00
	TOTALS		300,744	0		
	G - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	18,999		1.00
	TOTALS		0	18,999		
	H - EMPLOYEE OCC HEALTH PROCEDURES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,697	1,400		1.00
	TOTALS		2,697	1,400		
	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	114,257		2.00
3.00	OPERATION OF PLANT	7.00	0	23,901		3.00
	TOTALS		0	213,518		
	J - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	48,524		1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	151,311		2.00
3.00	RURAL HEALTH CLINIC (RHC) VANDALIA	88.00	0	358		3.00
4.00		0.00	0	0		4.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
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	200,193		
	K - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	47,890		1.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
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	47,890		
	L - ICU					
1.00	INTENSIVE CARE UNIT	31.00	101,684	7,618		1.00
	TOTALS		101,684	7,618		
	M - PROVIDER BASED					
1.00	DR SKOW	90.04	54,859	29		1.00
2.00	DR BLASER	90.05	51,106	1,466		2.00
	TOTALS		105,965	1,495		
500.00	Grand Total: Increases		595,352	1,530,641		500.00

RECLASSIFICATIONS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 11:12 am

		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	84,262	102,175	0		1.00
	TOTALS		84,262	102,175			
	B - CRNA						
1.00	OPERATING ROOM	50.00	0	292,483	0		1.00
	TOTALS		0	292,483			
	D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	644,870	9		1.00
	TOTALS		0	644,870			
	E - ER						
1.00	AMBULANCE SERVICES	95.00	300,744	0	0		1.00
	TOTALS		300,744	0			
	G - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	18,999	9		1.00
	TOTALS		0	18,999			
	H - EMPLOYEE OCC HEALTH PROCEDURES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,697	1,400	0		1.00
	TOTALS		2,697	1,400			
	I - WELLNESS DEPR AND UTILITIES						
1.00	FAYETTE COUNTY ANNEX	192.01	0	213,518	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	213,518			
	J - MED SUPPLY						
1.00		0.00	0	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	26,420	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	15,069	0		3.00
4.00	OPERATING ROOM	50.00	0	76,347	0		4.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,383	0		6.00
7.00	LABORATORY	60.00	0	1,954	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	23,865	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	149	0		9.00
14.00	CLINIC	90.00	0	3	0		14.00
15.00	EMERGENCY	91.00	0	47,866	0		15.00
16.00	AMBULANCE SERVICES	95.00	0	3,295	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,789	0		17.00
18.00	FAYETTE COUNTY ANNEX	192.01	0	53	0		18.00
	TOTALS		0	200,193			
	K - PHARMACY						
1.00	ADULTS & PEDIATRICS	30.00	0	2,908	0		1.00
3.00	SKILLED NURSING FACILITY	44.00	0	23,681	0		3.00
4.00	OPERATING ROOM	50.00	0	7,964	0		4.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	346	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,747	0		7.00
8.00	LABORATORY	60.00	0	1	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	5	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	19	0		10.00
11.00	RURAL HEALTH CLINIC (RHC) VANDALIA	88.00	0	174	0		11.00
13.00	EMERGENCY	91.00	0	5,779	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	2,872	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	394	0		15.00
	TOTALS		0	47,890			
	L - ICU						
1.00	ADULTS & PEDIATRICS	30.00	101,684	7,618	0		1.00
	TOTALS		101,684	7,618			
	M - PROVIDER BASED						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	105,965	1,495	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		105,965	1,495			
500.00	Grand Total: Decreases		595,352	1,530,641			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I Date/Time Prepared: 5/23/2017 11:12 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	33,453,136	1,882,641	0	1,882,641	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,453,136	1,882,641	0	1,882,641	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,453,136	1,882,641	0	1,882,641	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	35,335,777	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,335,777	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,335,777	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/23/2017 11:12 am

	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	1,770,751	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)	1,770,751	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	1,770,751	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,770,751	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2017 11:12 am

	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	35,335,777	0	35,335,777	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)	35,335,777	0	35,335,777	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	802,620	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	644,870	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,447,490	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	802,620	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	644,870	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,447,490	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/23/2017 11:12 am

	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	-102,333	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	-5,000	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	-1,888,543			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,651			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-78,366	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	-14,959	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	-1,742	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	-292,483	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	-379,622	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/23/2017 11:12 am

	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	MISCELLANEOUS REVENUE	B	-1,601	ADMINISTRATIVE & GENERAL	5.00	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	-664	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	-151,994	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	-128,619	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.)		-3,056,177				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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/23/2017 11:12 am

	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	621,932	621,932	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	BLUE GRASS LEASING	91,611	91,611	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	32,487	32,487	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	BLUE	164,275	164,275	4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	185,169	183,518	4.01
5.00	0		0	1,102,494	1,100,843	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: 14-1346	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/23/2017 11:12 am

	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	1,651	0		4.01
5.00	1,651			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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2017 11:12 am

	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	1,596,359	1,189,061	407,298	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	130,693	130,693	0	0	0	2.00
3.00	90.01	WOUND CARE	246,075	246,075	0	0	0	3.00
4.00	90.02	PAIN MANAGEMENT	107,500	107,500	0	0	0	4.00
5.00	90.03	NEUROLOGY	132,137	132,137	0	0	0	5.00
6.00	90.04	DR SKOW	39,212	39,212	0	0	0	6.00
7.00	90.05	DR BLASER	43,865	43,865	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			2,295,841	1,888,543	407,298		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	90.01	WOUND CARE	0	0	0	0	0	3.00
4.00	90.02	PAIN MANAGEMENT	0	0	0	0	0	4.00
5.00	90.03	NEUROLOGY	0	0	0	0	0	5.00
6.00	90.04	DR SKOW	0	0	0	0	0	6.00
7.00	90.05	DR BLASER	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	1,189,061		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	130,693		2.00
3.00	90.01	WOUND CARE	0	0	0	246,075		3.00
4.00	90.02	PAIN MANAGEMENT	0	0	0	107,500		4.00
5.00	90.03	NEUROLOGY	0	0	0	132,137		5.00
6.00	90.04	DR SKOW	0	0	0	39,212		6.00
7.00	90.05	DR BLASER	0	0	0	43,865		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	1,888,543		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 11:12 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	802,620	802,620				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	644,870		644,870			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,028,249	3,478	1,491	4,033,218		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,751,880	36,051	467,494	322,334	4,577,759	5.00
7.00	00700	OPERATION OF PLANT	342,773	268,471	8,192	92,471	711,907	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	601,486	0	0	0	601,486	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	12,615	0	0	0	12,615	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	125,172	13,788	0	29,310	168,270	8.00
9.00	00900	HOUSEKEEPING	498,523	3,931	0	143,130	645,584	9.00
10.00	01000	DIETARY	433,883	20,370	5,084	84,379	543,716	10.00
11.00	01100	CAFETERIA	186,437	0	0	30,710	217,147	11.00
13.00	01300	NURSING ADMINISTRATION	187,197	5,241	0	61,293	253,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139,429	4,770	0	20,004	164,203	14.00
15.00	01500	PHARMACY	358,471	0	0	70,145	428,616	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375,137	13,739	0	82,860	471,736	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	842,734	43,282	3,759	298,249	1,188,024	30.00
31.00	03100	INTENSIVE CARE UNIT	109,302	4,819	0	37,060	151,181	31.00
44.00	04400	SKILLED NURSING FACILITY	1,604,974	161,665	4,052	488,529	2,259,220	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	792,426	29,469	45,779	198,204	1,065,878	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,335,477	21,270	19,668	158,697	1,535,112	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	140,662	0	0	0	140,662	55.00
60.00	06000	LABORATORY	1,406,777	30,271	49,157	200,860	1,687,065	60.00
65.00	06500	RESPIRATORY THERAPY	235,194	12,717	9,320	54,619	311,850	65.00
66.00	06600	PHYSICAL THERAPY	439,043	7,053	3,016	145,157	594,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	68,077	1,041	0	23,133	92,251	67.00
68.00	06800	SPEECH PATHOLOGY	33,858	0	0	10,828	44,686	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	450,058	0	0	0	450,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	151,311	0	0	0	151,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,019,870	0	0	0	1,019,870	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	515,755	0	0	154,768	670,523	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	226,717	0	0	56,667	283,384	88.01
90.00	09000	CLINIC	601,400	32,396	0	0	633,796	90.00
90.01	09002	WOUND CARE	63,676	5,841	0	22,040	91,557	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	16,837	276	0	53,181	70,294	90.03
90.04	09004	DR SKOW	15,676	153	0	19,994	35,823	90.04
90.05	09005	DR BLASER	8,707	153	0	18,626	27,486	90.05
91.00	09100	EMERGENCY	1,603,670	17,260	143	464,187	2,085,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	131,981	0	3,645	26,297	161,923	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,302,924	737,505	620,800	3,367,732	23,548,253	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,472	0	0	3,472	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,155,773	48,853	12,976	634,991	2,852,593	192.00
192.01	19201	FAYETTE COUNTY ANNEX	-53	12,790	11,094	30,495	54,326	192.01
192.02	19202	PUBLIC RELATIONS	42,108	0	0	0	42,108	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)	26,500,752	802,620	644,870	4,033,218	26,500,752	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 11:12 am

		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	4,577,759					5.00
7.00	00700	OPERATION OF PLANT	148,654	860,561				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	125,597	0	727,083			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	2,634	0	0	15,249		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	35,137	23,990	21,689	0	249,086	8.00
9.00	00900	HOUSEKEEPING	134,805	6,839	6,183	0	16,773	9.00
10.00	01000	DIETARY	113,534	35,441	32,043	0	2,919	10.00
11.00	01100	CAFETERIA	45,343	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	52,982	9,119	8,244	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,287	8,298	7,503	0	0	14.00
15.00	01500	PHARMACY	89,500	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,504	23,904	21,612	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	248,072	75,303	68,082	0	33,346	30.00
31.00	03100	INTENSIVE CARE UNIT	31,568	8,384	7,580	0	73	31.00
44.00	04400	SKILLED NURSING FACILITY	471,750	281,273	254,301	0	128,168	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	222,567	51,271	46,355	0	12,429	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	320,548	37,007	33,459	0	4,038	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	29,372	0	0	0	0	55.00
60.00	06000	LABORATORY	352,278	52,667	47,616	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	65,118	22,125	20,004	0	22	65.00
66.00	06600	PHYSICAL THERAPY	124,090	12,272	11,095	0	10,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,263	1,811	1,637	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,331	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,977	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	31,595	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,960	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	140,013	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	59,174	0	0	0	0	88.01
90.00	09000	CLINIC	132,344	56,363	0	15,249	0	90.00
90.01	09002	WOUND CARE	19,118	10,163	9,188	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	14,678	479	433	0	0	90.03
90.04	09004	DR SKOW	7,480	266	241	0	0	90.04
90.05	09005	DR BLASER	5,739	266	241	0	0	90.05
91.00	09100	EMERGENCY	435,425	30,030	27,150	0	21,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	33,811	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,961,248	747,271	624,656	15,249	229,680	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	725	6,040	5,461	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	595,649	84,997	76,847	0	273	192.00
192.01	19201	FAYETTE COUNTY ANNEX	11,344	22,253	20,119	0	503	192.01
192.02	19202	PUBLIC RELATIONS	8,793	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	18,630	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)	4,577,759	860,561	727,083	15,249	249,086	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 11:12 am

		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	810,184					9.00
10.00	01000	DIETARY	34,606	762,259				10.00
11.00	01100	CAFETERIA	0	0	262,490			11.00
13.00	01300	NURSING ADMINISTRATION	8,904	0	10,458	343,438		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,103	0	4,315	0	226,709	14.00
15.00	01500	PHARMACY	0	0	4,828	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,341	0	9,204	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	73,529	81,323	28,209	98,711	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,186	1,715	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	274,646	636,024	73,533	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,063	0	14,937	52,267	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,135	0	16,210	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	51,426	0	23,422	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,604	0	5,773	0	0	65.00
66.00	06600	PHYSICAL THERAPY	11,983	0	10,951	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,768	0	1,294	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	699	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	165,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	61,518	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	27,751	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	14,451	0	88.01
90.00	09000	CLINIC	55,035	43,197	0	0	0	90.00
90.01	09002	WOUND CARE	9,923	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	468	0	0	0	0	90.03
90.04	09004	DR SKOW	260	0	0	0	0	90.04
90.05	09005	DR BLASER	260	0	0	0	0	90.05
91.00	09100	EMERGENCY	29,322	0	39,673	138,827	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	3,267	11,431	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	699,562	762,259	246,773	343,438	226,709	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,898	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,995	0	15,717	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	21,729	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)	810,184	762,259	262,490	343,438	226,709	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 11:12 am

		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	522,944					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	648,301				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	29,555	0	1,924,154	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	208,687	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	30,215	0	4,409,130	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	24,496	0	1,540,263	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	145,169	0	2,127,678	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,822	0	175,856	0	55.00
60.00	06000	LABORATORY	0	131,997	0	2,346,471	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,570	0	464,066	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,433	0	790,749	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,331	0	120,355	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	495	0	55,211	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,278	0	726,504	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,878	0	250,302	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	522,944	58,999	0	1,814,773	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	3,226	0	841,513	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	2,593	0	359,602	0	88.01
90.00	09000	CLINIC	0	19,498	0	955,482	0	90.00
90.01	09002	WOUND CARE	0	7,859	0	147,808	0	90.01
90.02	09003	PAIN MANAGEMENT	0	1,682	0	1,682	0	90.02
90.03	09001	NEUROLOGY	0	0	0	86,352	0	90.03
90.04	09004	DR SKOW	0	0	0	44,070	0	90.04
90.05	09005	DR BLASER	0	0	0	33,992	0	90.05
91.00	09100	EMERGENCY	0	71,540	0	2,878,483	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	13,030	0	223,462	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	522,944	604,666	0	22,526,645	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	21,596	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,635	0	3,752,706	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	130,274	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	50,901	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	18,630	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)	522,944	648,301	0	26,500,752	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/23/2017 11:12 am

		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	1,924,154		30.00
31.00	03100	INTENSIVE CARE UNIT	208,687		31.00
44.00	04400	SKILLED NURSING FACILITY	4,409,130		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,540,263		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,127,678		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	175,856		55.00
60.00	06000	LABORATORY	2,346,471		60.00
65.00	06500	RESPIRATORY THERAPY	464,066		65.00
66.00	06600	PHYSICAL THERAPY	790,749		66.00
67.00	06700	OCCUPATIONAL THERAPY	120,355		67.00
68.00	06800	SPEECH PATHOLOGY	55,211		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	726,504		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	250,302		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,814,773		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	841,513		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	359,602		88.01
90.00	09000	CLINIC	955,482		90.00
90.01	09002	WOUND CARE	147,808		90.01
90.02	09003	PAIN MANAGEMENT	1,682		90.02
90.03	09001	NEUROLOGY	86,352		90.03
90.04	09004	DR SKOW	44,070		90.04
90.05	09005	DR BLASER	33,992		90.05
91.00	09100	EMERGENCY	2,878,483		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	223,462		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,526,645		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,596		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,752,706		192.00
192.01	19201	FAYETTE COUNTY ANNEX	130,274		192.01
192.02	19202	PUBLIC RELATIONS	50,901		192.02
192.03	19203	PERSONAL LAUNDRY	18,630		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)	26,500,752		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 11:12 am

		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	3,478	1,491	4,969	4,969	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	36,051	467,494	503,545	397	5.00
7.00	00700	OPERATION OF PLANT	0	268,471	8,192	276,663	114	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	13,788	0	13,788	36	8.00
9.00	00900	HOUSEKEEPING	0	3,931	0	3,931	176	9.00
10.00	01000	DIETARY	0	20,370	5,084	25,454	104	10.00
11.00	01100	CAFETERIA	0	0	0	0	38	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,241	0	5,241	76	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,770	0	4,770	25	14.00
15.00	01500	PHARMACY	0	0	0	0	86	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,739	0	13,739	102	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	43,282	3,759	47,041	367	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,819	0	4,819	46	31.00
44.00	04400	SKILLED NURSING FACILITY	0	161,665	4,052	165,717	602	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,469	45,779	75,248	244	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,270	19,668	40,938	196	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	30,271	49,157	79,428	247	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,717	9,320	22,037	67	65.00
66.00	06600	PHYSICAL THERAPY	0	7,053	3,016	10,069	179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,041	0	1,041	28	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	13	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	191	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	0	70	88.01
90.00	09000	CLINIC	0	32,396	0	32,396	0	90.00
90.01	09002	WOUND CARE	0	5,841	0	5,841	27	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	276	0	276	66	90.03
90.04	09004	DR SKOW	0	153	0	153	25	90.04
90.05	09005	DR BLASER	0	153	0	153	23	90.05
91.00	09100	EMERGENCY	0	17,260	143	17,403	572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	3,645	3,645	32	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	737,505	620,800	1,358,305	4,149	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,472	0	3,472	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	48,853	12,976	61,829	782	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	12,790	11,094	23,884	38	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	802,620	644,870	1,447,490	4,969	202.00

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		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	503,942					5.00
7.00	00700	OPERATION OF PLANT	16,365	293,142				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	13,826	0	13,826			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	290	0	0	290		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	3,868	8,172	412	0	26,276	8.00
9.00	00900	HOUSEKEEPING	14,840	2,330	118	0	1,769	9.00
10.00	01000	DIETARY	12,498	12,073	609	0	308	10.00
11.00	01100	CAFETERIA	4,992	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,833	3,106	157	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,775	2,827	143	0	0	14.00
15.00	01500	PHARMACY	9,853	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,844	8,143	411	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	27,309	25,651	1,295	0	3,518	30.00
31.00	03100	INTENSIVE CARE UNIT	3,475	2,856	144	0	8	31.00
44.00	04400	SKILLED NURSING FACILITY	51,933	95,812	4,836	0	13,521	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,501	17,465	881	0	1,311	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,288	12,606	636	0	426	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,233	0	0	0	0	55.00
60.00	06000	LABORATORY	38,781	17,940	905	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,168	7,537	380	0	2	65.00
66.00	06600	PHYSICAL THERAPY	13,660	4,180	211	0	1,124	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,121	617	31	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,027	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,345	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,478	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,444	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	15,413	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	6,514	0	0	0	0	88.01
90.00	09000	CLINIC	14,569	19,200	0	290	0	90.00
90.01	09002	WOUND CARE	2,105	3,462	175	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	1,616	163	8	0	0	90.03
90.04	09004	DR SKOW	823	91	5	0	0	90.04
90.05	09005	DR BLASER	632	91	5	0	0	90.05
91.00	09100	EMERGENCY	47,934	10,229	516	0	2,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,722	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	436,075	254,551	11,878	290	24,229	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	80	2,057	104	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65,570	28,954	1,461	0	29	192.00
192.01	19201	FAYETTE COUNTY ANNEX	1,249	7,580	383	0	53	192.01
192.02	19202	PUBLIC RELATIONS	968	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	1,965	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)	503,942	293,142	13,826	290	26,276	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/23/2017 11:12 am

		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	23,164					9.00
10.00	01000	DIETARY	989	52,035				10.00
11.00	01100	CAFETERIA	0	0	5,030			11.00
13.00	01300	NURSING ADMINISTRATION	255	0	200	14,868		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	232	0	83	0	11,855	14.00
15.00	01500	PHARMACY	0	0	93	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	667	0	176	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	2,102	5,551	541	4,273	0	30.00
31.00	03100	INTENSIVE CARE UNIT	234	117	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	7,853	43,418	1,408	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,431	0	286	2,263	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,033	0	311	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,470	0	449	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	618	0	111	0	0	65.00
66.00	06600	PHYSICAL THERAPY	343	0	210	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	51	0	25	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	13	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	0	1,201	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	0	626	0	88.01
90.00	09000	CLINIC	1,574	2,949	0	0	0	90.00
90.01	09002	WOUND CARE	284	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	13	0	0	0	0	90.03
90.04	09004	DR SKOW	7	0	0	0	0	90.04
90.05	09005	DR BLASER	7	0	0	0	0	90.05
91.00	09100	EMERGENCY	838	0	760	6,010	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	63	495	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,001	52,035	4,729	14,868	11,855	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	169	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,373	0	301	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	621	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)	23,164	52,035	5,030	14,868	11,855	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 11:12 am

		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	10,032					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,082				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,552		119,200	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		11,699	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	1,587		386,687	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,287		124,917	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,655		99,089	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	306		3,539	0	55.00
60.00	06000	LABORATORY	0	6,933		146,153	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	923		38,843	0	65.00
66.00	06600	PHYSICAL THERAPY	0	811		30,787	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	122		4,036	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	26		1,079	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	908		19,891	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	309		7,004	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,032	3,099		36,575	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	169		16,974	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	136		7,346	0	88.01
90.00	09000	CLINIC	0	1,024		72,002	0	90.00
90.01	09002	WOUND CARE	0	413		12,307	0	90.01
90.02	09003	PAIN MANAGEMENT	0	88		88	0	90.02
90.03	09001	NEUROLOGY	0	0		2,142	0	90.03
90.04	09004	DR SKOW	0	0		1,104	0	90.04
90.05	09005	DR BLASER	0	0		911	0	90.05
91.00	09100	EMERGENCY	0	3,758		90,262	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	684		8,641	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,032	31,790	0	1,241,276	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		5,882	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,292		163,591	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		33,808	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0		968	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0		1,965	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)	10,032	34,082	0	1,447,490	0	202.00

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		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	119,200		30.00
31.00	03100	INTENSIVE CARE UNIT	11,699		31.00
44.00	04400	SKILLED NURSING FACILITY	386,687		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	124,917		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,089		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,539		55.00
60.00	06000	LABORATORY	146,153		60.00
65.00	06500	RESPIRATORY THERAPY	38,843		65.00
66.00	06600	PHYSICAL THERAPY	30,787		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,036		67.00
68.00	06800	SPEECH PATHOLOGY	1,079		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,891		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,004		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,575		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	16,974		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	7,346		88.01
90.00	09000	CLINIC	72,002		90.00
90.01	09002	WOUND CARE	12,307		90.01
90.02	09003	PAIN MANAGEMENT	88		90.02
90.03	09001	NEUROLOGY	2,142		90.03
90.04	09004	DR SKOW	1,104		90.04
90.05	09005	DR BLASER	911		90.05
91.00	09100	EMERGENCY	90,262		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	8,641		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,241,276		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,882		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	163,591		192.00
192.01	19201	FAYETTE COUNTY ANNEX	33,808		192.01
192.02	19202	PUBLIC RELATIONS	968		192.02
192.03	19203	PERSONAL LAUNDRY	1,965		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)	1,447,490		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 11:12 am

		Cost Center Description	CAPITAL RELATED COSTS: NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS: 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	131,088					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		644,870				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	568	1,491	11,066,181			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,888	467,494	884,408	-4,577,759	21,922,993	5.00
7.00	00700	OPERATION OF PLANT	43,848	8,192	253,718	0	711,907	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	601,486	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	12,615	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,252	0	80,420	0	168,270	8.00
9.00	00900	HOUSEKEEPING	642	0	392,714	0	645,584	9.00
10.00	01000	DIETARY	3,327	5,084	231,517	0	543,716	10.00
11.00	01100	CAFETERIA	0	0	84,262	0	217,147	11.00
13.00	01300	NURSING ADMINISTRATION	856	0	168,174	0	253,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	779	0	54,885	0	164,203	14.00
15.00	01500	PHARMACY	0	0	192,462	0	428,616	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,244	0	227,347	0	471,736	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,069	3,759	818,325	0	1,188,024	30.00
31.00	03100	INTENSIVE CARE UNIT	787	0	101,684	0	151,181	31.00
44.00	04400	SKILLED NURSING FACILITY	26,404	4,052	1,340,407	0	2,259,220	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,813	45,779	543,824	0	1,065,878	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,474	19,668	435,428	0	1,535,112	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	140,662	55.00
60.00	06000	LABORATORY	4,944	49,157	551,113	0	1,687,065	60.00
65.00	06500	RESPIRATORY THERAPY	2,077	9,320	149,861	0	311,850	65.00
66.00	06600	PHYSICAL THERAPY	1,152	3,016	398,275	0	594,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	0	63,471	0	92,251	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	29,710	0	44,686	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	450,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	151,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,019,870	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	0	424,646	0	670,523	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	155,482	0	283,384	88.01
90.00	09000	CLINIC	5,291	0	0	0	633,796	90.00
90.01	09002	WOUND CARE	954	0	60,473	0	91,557	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	45	0	145,915	0	70,294	90.03
90.04	09004	DR SKOW	25	0	54,859	0	35,823	90.04
90.05	09005	DR BLASER	25	0	51,106	0	27,486	90.05
91.00	09100	EMERGENCY	2,819	143	1,273,619	0	2,085,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,645	72,154	0	161,923	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	120,453	620,800	9,240,259	-4,577,759	18,970,494	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	567	0	0	0	3,472	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,979	12,976	1,742,252	0	2,852,593	192.00
192.01	19201	FAYETTE COUNTY ANNEX	2,089	11,094	83,670	0	54,326	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	42,108	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)	802,620	644,870	4,033,218		4,577,759	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.122757	1.000000	0.364463		0.208811	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,969		503,942	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000449		0.022987	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 11:12 am

		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	80,784					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	75,493				7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	5,291			7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,252	2,252	0	396,511		8.00
9.00	00900	HOUSEKEEPING	642	642	0	26,700	77,890	9.00
10.00	01000	DIETARY	3,327	3,327	0	4,646	3,327	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	856	856	0	0	856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	779	779	0	0	779	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,244	2,244	0	0	2,244	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,069	7,069	0	53,082	7,069	30.00
31.00	03100	INTENSIVE CARE UNIT	787	787	0	117	787	31.00
44.00	04400	SKILLED NURSING FACILITY	26,404	26,404	0	204,027	26,404	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,813	4,813	0	19,786	4,813	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,474	3,474	0	6,428	3,474	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	4,944	4,944	0	0	4,944	60.00
65.00	06500	RESPIRATORY THERAPY	2,077	2,077	0	35	2,077	65.00
66.00	06600	PHYSICAL THERAPY	1,152	1,152	0	16,963	1,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	170	0	0	170	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	5,291	0	5,291	0	5,291	90.00
90.01	09002	WOUND CARE	954	954	0	0	954	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	45	45	0	0	45	90.03
90.04	09004	DR SKOW	25	25	0	0	25	90.04
90.05	09005	DR BLASER	25	25	0	0	25	90.05
91.00	09100	EMERGENCY	2,819	2,819	0	33,836	2,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,149	64,858	5,291	365,620	67,255	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	567	567	0	0	567	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,979	7,979	0	435	7,979	192.00
192.01	19201	FAYETTE COUNTY ANNEX	2,089	2,089	0	800	2,089	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	29,656	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)	860,561	727,083	15,249	249,086	810,184	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.652617	9.631131	2.882064	0.628194	10.401643	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	293,142	13,826	290	26,276	23,164	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.628714	0.183143	0.054810	0.066268	0.297394	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 11:12 am

		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	62,238					10.00
11.00	01100	CAFETERIA	0	12,776				11.00
13.00	01300	NURSING ADMINISTRATION	0	509	4,777			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	210	0	601,369		14.00
15.00	01500	PHARMACY	0	235	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	448	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	6,640	1,373	1,373	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	140	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	51,931	3,579	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	727	727	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	789	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	1,140	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	281	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	533	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	63	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	34	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	438,185	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	163,184	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	386	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	0	201	0	0	88.01
90.00	09000	CLINIC	3,527	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	1,931	1,931	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	159	159	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,238	12,011	4,777	601,369	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	765	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)	762,259	262,490	343,438	226,709	522,944	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.247485	20.545554	71.894076	0.376988	5,229.440000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,035	5,030	14,868	11,855	10,032	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.836065	0.393707	3.112414	0.019713	100.320000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 11:12 am

		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	71,993,619			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,282,050	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	3,355,387	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,720,219	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,121,162	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	646,530	0		55.00
60.00	06000	LABORATORY	14,658,188	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,951,097	0		65.00
66.00	06600	PHYSICAL THERAPY	1,713,819	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	258,827	0		67.00
68.00	06800	SPEECH PATHOLOGY	54,994	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,918,678	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	652,737	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,551,852	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	358,242	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	287,992	0		88.01
90.00	09000	CLINIC	2,165,259	0		90.00
90.01	09002	WOUND CARE	872,731	0		90.01
90.02	09003	PAIN MANAGEMENT	186,780	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	0	0		90.04
90.05	09005	DR BLASER	0	0		90.05
91.00	09100	EMERGENCY	7,944,501	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,446,964	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,148,009	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,845,610	0		192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0		192.01
192.02	19202	PUBLIC RELATIONS	0	0		192.02
192.03	19203	PERSONAL LAUNDRY	0	0		192.03
192.04	19204	VIS MEALS & MEALS ON WHEELS	0	0		192.04
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	648,301	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009005	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,082	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000473	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 11:12 am

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		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	1,924,154		1,924,154	0	1,924,154	30.00
31.00	03100	INTENSIVE CARE UNIT	208,687		208,687	0	208,687	31.00
44.00	04400	SKILLED NURSING FACILITY	4,409,130		4,409,130	0	4,409,130	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,540,263		1,540,263	0	1,540,263	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,127,678		2,127,678	0	2,127,678	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	175,856		175,856	0	175,856	55.00
60.00	06000	LABORATORY	2,346,471		2,346,471	0	2,346,471	60.00
65.00	06500	RESPIRATORY THERAPY	464,066	0	464,066	0	464,066	65.00
66.00	06600	PHYSICAL THERAPY	790,749	0	790,749	0	790,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,355	0	120,355	0	120,355	67.00
68.00	06800	SPEECH PATHOLOGY	55,211	0	55,211	0	55,211	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	726,504		726,504	0	726,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	250,302		250,302	0	250,302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,814,773		1,814,773	0	1,814,773	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	841,513		841,513	0	841,513	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	359,602		359,602	0	359,602	88.01
90.00	09000	CLINIC	955,482		955,482	0	955,482	90.00
90.01	09002	WOUND CARE	147,808		147,808	0	147,808	90.01
90.02	09003	PAIN MANAGEMENT	1,682		1,682	0	1,682	90.02
90.03	09001	NEUROLOGY	86,352		86,352	0	86,352	90.03
90.04	09004	DR SKOW	44,070		44,070	0	44,070	90.04
90.05	09005	DR BLASER	33,992		33,992	0	33,992	90.05
91.00	09100	EMERGENCY	2,878,483		2,878,483	0	2,878,483	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	553,375		553,375		553,375	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	223,462		223,462	0	223,462	95.00
200.00		Subtotal (see instructions)	23,080,020	0	23,080,020	0	23,080,020	200.00
201.00		Less Observation Beds	553,375		553,375		553,375	201.00
202.00		Total (see instructions)	22,526,645	0	22,526,645	0	22,526,645	202.00

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		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	1,499,890		1,499,890			30.00
31.00	03100	INTENSIVE CARE UNIT	136,204		136,204			31.00
44.00	04400	SKILLED NURSING FACILITY	3,355,387		3,355,387			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	114,967	2,605,253	2,720,220	0.566227	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	459,100	15,662,063	16,121,163	0.131980	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	63,088	583,442	646,530	0.272000	0.000000	55.00
60.00	06000	LABORATORY	978,457	13,679,730	14,658,187	0.160079	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	472,837	1,478,260	1,951,097	0.237849	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	302,087	1,411,732	1,713,819	0.461396	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	92,572	166,255	258,827	0.465002	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	11,247	43,747	54,994	1.003946	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	820,425	1,098,253	1,918,678	0.378648	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	488,924	163,813	652,737	0.383465	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,551,564	5,000,288	6,551,852	0.276986	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	358,242	358,242			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	287,992	287,992			88.01
90.00	09000	CLINIC	0	2,165,259	2,165,259	0.441278	0.000000	90.00
90.01	09002	WOUND CARE	0	697,054	697,054	0.212047	0.000000	90.01
90.02	09003	PAIN MANAGEMENT	0	1,535	1,535	1.095765	0.000000	90.02
90.03	09001	NEUROLOGY	0	32,230	32,230	2.679243	0.000000	90.03
90.04	09004	DR SKOW	0	13,084	13,084	3.368236	0.000000	90.04
90.05	09005	DR BLASER	0	19,943	19,943	1.704458	0.000000	90.05
91.00	09100	EMERGENCY	36,446	7,908,056	7,944,502	0.362324	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	17,611	1,711,346	1,728,957	0.320063	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,446,965	1,446,965	0.154435	0.000000	95.00
200.00		Subtotal (see instructions)	10,400,806	56,534,542	66,935,348			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,400,806	56,534,542	66,935,348			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 11:12 am

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
90.02	09003	PAIN MANAGEMENT	0.000000		90.02
90.03	09001	NEUROLOGY	0.000000		90.03
90.04	09004	DR SKOW	0.000000		90.04
90.05	09005	DR BLASER	0.000000		90.05
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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 11:12 am

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	1,924,154		1,924,154	0	1,924,154	30.00
31.00	03100	INTENSIVE CARE UNIT	208,687		208,687	0	208,687	31.00
44.00	04400	SKILLED NURSING FACILITY	4,409,130		4,409,130	0	4,409,130	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,540,263		1,540,263	0	1,540,263	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,127,678		2,127,678	0	2,127,678	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	175,856		175,856	0	175,856	55.00
60.00	06000	LABORATORY	2,346,471		2,346,471	0	2,346,471	60.00
65.00	06500	RESPIRATORY THERAPY	464,066	0	464,066	0	464,066	65.00
66.00	06600	PHYSICAL THERAPY	790,749	0	790,749	0	790,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,355	0	120,355	0	120,355	67.00
68.00	06800	SPEECH PATHOLOGY	55,211	0	55,211	0	55,211	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	726,504		726,504	0	726,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	250,302		250,302	0	250,302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,814,773		1,814,773	0	1,814,773	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	841,513		841,513	0	841,513	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	359,602		359,602	0	359,602	88.01
90.00	09000	CLINIC	955,482		955,482	0	955,482	90.00
90.01	09002	WOUND CARE	147,808		147,808	0	147,808	90.01
90.02	09003	PAIN MANAGEMENT	1,682		1,682	0	1,682	90.02
90.03	09001	NEUROLOGY	86,352		86,352	0	86,352	90.03
90.04	09004	DR SKOW	44,070		44,070	0	44,070	90.04
90.05	09005	DR BLASER	33,992		33,992	0	33,992	90.05
91.00	09100	EMERGENCY	2,878,483		2,878,483	0	2,878,483	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	553,375		553,375		553,375	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	223,462		223,462	0	223,462	95.00
200.00		Subtotal (see instructions)	23,080,020	0	23,080,020	0	23,080,020	200.00
201.00		Less Observation Beds	553,375		553,375		553,375	201.00
202.00		Total (see instructions)	22,526,645	0	22,526,645	0	22,526,645	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 11:12 am

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	1,499,890		1,499,890			30.00
31.00	03100	INTENSIVE CARE UNIT	136,204		136,204			31.00
44.00	04400	SKILLED NURSING FACILITY	3,355,387		3,355,387			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	114,967	2,605,253	2,720,220	0.566227	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	459,100	15,662,063	16,121,163	0.131980	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	63,088	583,442	646,530	0.272000	0.000000	55.00
60.00	06000	LABORATORY	978,457	13,679,730	14,658,187	0.160079	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	472,837	1,478,260	1,951,097	0.237849	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	302,087	1,411,732	1,713,819	0.461396	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	92,572	166,255	258,827	0.465002	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	11,247	43,747	54,994	1.003946	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	820,425	1,098,253	1,918,678	0.378648	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	488,924	163,813	652,737	0.383465	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,551,564	5,000,288	6,551,852	0.276986	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	358,242	358,242	2.349007	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	287,992	287,992	1.248653	0.000000	88.01
90.00	09000	CLINIC	0	2,165,259	2,165,259	0.441278	0.000000	90.00
90.01	09002	WOUND CARE	0	697,054	697,054	0.212047	0.000000	90.01
90.02	09003	PAIN MANAGEMENT	0	1,535	1,535	1.095765	0.000000	90.02
90.03	09001	NEUROLOGY	0	32,230	32,230	2.679243	0.000000	90.03
90.04	09004	DR SKOW	0	13,084	13,084	3.368236	0.000000	90.04
90.05	09005	DR BLASER	0	19,943	19,943	1.704458	0.000000	90.05
91.00	09100	EMERGENCY	36,446	7,908,056	7,944,502	0.362324	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	17,611	1,711,346	1,728,957	0.320063	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,446,965	1,446,965	0.154435	0.000000	95.00
200.00		Subtotal (see instructions)	10,400,806	56,534,542	66,935,348			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,400,806	56,534,542	66,935,348			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 11:12 am

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
90.02	09003	PAIN MANAGEMENT	0.000000		90.02
90.03	09001	NEUROLOGY	0.000000		90.03
90.04	09004	DR SKOW	0.000000		90.04
90.05	09005	DR BLASER	0.000000		90.05
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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/23/2017 11:12 am

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	124,917	2,720,220	0.045922	67,477	3,099	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,089	16,121,163	0.006147	169,287	1,041	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,539	646,530	0.005474	51,292	281	55.00
60.00	06000	LABORATORY	146,153	14,658,187	0.009971	575,713	5,740	60.00
65.00	06500	RESPIRATORY THERAPY	38,843	1,951,097	0.019908	274,867	5,472	65.00
66.00	06600	PHYSICAL THERAPY	30,787	1,713,819	0.017964	50,469	907	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,036	258,827	0.015593	5,155	80	67.00
68.00	06800	SPEECH PATHOLOGY	1,079	54,994	0.019620	2,470	48	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,891	1,918,678	0.010367	495,213	5,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,004	652,737	0.010730	151,806	1,629	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,575	6,551,852	0.005582	629,974	3,517	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	16,974	358,242	0.047381	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	7,346	287,992	0.025508	0	0	88.01
90.00	09000	CLINIC	72,002	2,165,259	0.033253	0	0	90.00
90.01	09002	WOUND CARE	12,307	697,054	0.017656	0	0	90.01
90.02	09003	PAIN MANAGEMENT	88	1,535	0.057329	0	0	90.02
90.03	09001	NEUROLOGY	2,142	32,230	0.066460	0	0	90.03
90.04	09004	DR SKOW	1,104	13,084	0.084378	0	0	90.04
90.05	09005	DR BLASER	911	19,943	0.045680	0	0	90.05
91.00	09100	EMERGENCY	90,262	7,944,502	0.011362	1,057	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	34,281	1,728,957	0.019828	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	749,330	60,496,902		2,474,780	26,960	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/23/2017 11:12 am

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
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	90.05
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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/23/2017 11:12 am

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	2,720,220	0.000000	0.000000	67,477	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,121,163	0.000000	0.000000	169,287	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	646,530	0.000000	0.000000	51,292	55.00
60.00	06000	LABORATORY	0	14,658,187	0.000000	0.000000	575,713	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,951,097	0.000000	0.000000	274,867	65.00
66.00	06600	PHYSICAL THERAPY	0	1,713,819	0.000000	0.000000	50,469	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	258,827	0.000000	0.000000	5,155	67.00
68.00	06800	SPEECH PATHOLOGY	0	54,994	0.000000	0.000000	2,470	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,918,678	0.000000	0.000000	495,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	652,737	0.000000	0.000000	151,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,551,852	0.000000	0.000000	629,974	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	358,242	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	287,992	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	2,165,259	0.000000	0.000000	0	90.00
90.01	09002	WOUND CARE	0	697,054	0.000000	0.000000	0	90.01
90.02	09003	PAIN MANAGEMENT	0	1,535	0.000000	0.000000	0	90.02
90.03	09001	NEUROLOGY	0	32,230	0.000000	0.000000	0	90.03
90.04	09004	DR SKOW	0	13,084	0.000000	0.000000	0	90.04
90.05	09005	DR BLASER	0	19,943	0.000000	0.000000	0	90.05
91.00	09100	EMERGENCY	0	7,944,502	0.000000	0.000000	1,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,728,957	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	60,496,902			2,474,780	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/23/2017 11:12 am

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
90.02	09003	PAIN MANAGEMENT	0	0	0		90.02
90.03	09001	NEUROLOGY	0	0	0		90.03
90.04	09004	DR SKOW	0	0	0		90.04
90.05	09005	DR BLASER	0	0	0		90.05
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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 11:12 am

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	0.566227	0	1,086,095	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131980	0	5,791,530	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272000	0	429,097	0	0	55.00
60.00	06000	LABORATORY	0.160079	0	6,524,978	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.237849	0	999,383	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.461396	0	506,472	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465002	0	53,258	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.003946	0	6,770	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.378648	0	456,737	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.383465	0	60,229	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276986	0	3,597,353	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	0.441278	0	2,048,419	0	0	90.00
90.01	09002	WOUND CARE	0.212047	0	437,409	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.095765	0	425	0	0	90.02
90.03	09001	NEUROLOGY	2.679243	0	7,359	0	0	90.03
90.04	09004	DR SKOW	3.368236	0	2,697	0	0	90.04
90.05	09005	DR BLASER	1.704458	0	1,874	0	0	90.05
91.00	09100	EMERGENCY	0.362324	0	1,983,655	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320063	0	360,903	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.154435		0			95.00
200.00		Subtotal (see instructions)		0	24,354,643	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	24,354,643	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 11:12 am

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	614,976	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	764,366	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	116,714	0		55.00
60.00	06000	LABORATORY	1,044,512	0		60.00
65.00	06500	RESPIRATORY THERAPY	237,702	0		65.00
66.00	06600	PHYSICAL THERAPY	233,684	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	24,765	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,797	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172,943	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,096	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	996,416	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	903,922	0		90.00
90.01	09002	WOUND CARE	92,751	0		90.01
90.02	09003	PAIN MANAGEMENT	466	0		90.02
90.03	09001	NEUROLOGY	19,717	0		90.03
90.04	09004	DR SKOW	9,084	0		90.04
90.05	09005	DR BLASER	3,194	0		90.05
91.00	09100	EMERGENCY	718,726	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	115,512	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,099,343	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,099,343	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346 | Component CCN: 14-Z346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 11:12 am

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	0.566227	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131980	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.160079	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.237849	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.461396	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465002	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.003946	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.378648	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.383465	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276986	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	0.441278	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.212047	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.095765	0	0	0	0	90.02
90.03	09001	NEUROLOGY	2.679243	0	0	0	0	90.03
90.04	09004	DR SKOW	3.368236	0	0	0	0	90.04
90.05	09005	DR BLASER	1.704458	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.362324	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320063	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.154435		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: 14-1346 | Component CCN: 14-Z346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/23/2017 11:12 am

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
90.02	09003	PAIN MANAGEMENT	0	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	0	0		90.04
90.05	09005	DR BLASER	0	0		90.05
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: 14-1346
Component CCN: 14-5499

Period:
From 01/01/2016
To 12/31/2016

Worksheet D
Part IV
Date/Time Prepared:
5/23/2017 11:12 am

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
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	90.05
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: 14-1346 | Component CCN: 14-5499 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/23/2017 11:12 am

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	2,720,220	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	16,121,163	0.000000	0.000000	11,440	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	646,530	0.000000	0.000000	0	55.00
60.00	06000	LABORATORY	0	14,658,187	0.000000	0.000000	12,933	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,951,097	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,713,819	0.000000	0.000000	70,655	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	258,827	0.000000	0.000000	28,254	67.00
68.00	06800	SPEECH PATHOLOGY	0	54,994	0.000000	0.000000	2,003	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,918,678	0.000000	0.000000	7,926	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	652,737	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,551,852	0.000000	0.000000	155,830	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	0	358,242	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	0	287,992	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	2,165,259	0.000000	0.000000	0	90.00
90.01	09002	WOUND CARE	0	697,054	0.000000	0.000000	0	90.01
90.02	09003	PAIN MANAGEMENT	0	1,535	0.000000	0.000000	0	90.02
90.03	09001	NEUROLOGY	0	32,230	0.000000	0.000000	0	90.03
90.04	09004	DR SKOW	0	13,084	0.000000	0.000000	0	90.04
90.05	09005	DR BLASER	0	19,943	0.000000	0.000000	0	90.05
91.00	09100	EMERGENCY	0	7,944,502	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,728,957	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	60,496,902			289,041	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1346
Component CCN: 14-5499
Period: From 01/01/2016 To 12/31/2016
Worksheet D Part IV
Date/Time Prepared: 5/23/2017 11:12 am

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
90.02	09003	PAIN MANAGEMENT	0	0	0		90.02
90.03	09001	NEUROLOGY	0	0	0		90.03
90.04	09004	DR SKOW	0	0	0		90.04
90.05	09005	DR BLASER	0	0	0		90.05
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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 11:12 am

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	0.566227	0	464,729	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131980	0	4,633,979	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272000	0	111,202	0	0	55.00
60.00	06000	LABORATORY	0.160079	0	2,719,682	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.237849	0	111,190	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.461396	0	229,344	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465002	0	42,547	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.003946	0	7,455	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.378648	0	306,975	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.383465	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276986	0	1,023,920	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	2.349007				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	1.248653				0	88.01
90.00	09000	CLINIC	0.441278	0	12,038	0	0	90.00
90.01	09002	WOUND CARE	0.212047	0	93,287	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.095765	0	383	0	0	90.02
90.03	09001	NEUROLOGY	2.679243	0	0	0	0	90.03
90.04	09004	DR SKOW	3.368236	0	0	0	0	90.04
90.05	09005	DR BLASER	1.704458	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.362324	0	3,032,492	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320063	0	409,780	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.154435	0	0			95.00
200.00		Subtotal (see instructions)		0	13,199,003	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	13,199,003	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 11:12 am

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	263,142	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	611,593	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	30,247	0		55.00
60.00	06000	LABORATORY	435,364	0		60.00
65.00	06500	RESPIRATORY THERAPY	26,446	0		65.00
66.00	06600	PHYSICAL THERAPY	105,818	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	19,784	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,484	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,235	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	283,612	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	5,312	0		90.00
90.01	09002	WOUND CARE	19,781	0		90.01
90.02	09003	PAIN MANAGEMENT	420	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	0	0		90.04
90.05	09005	DR BLASER	0	0		90.05
91.00	09100	EMERGENCY	1,098,745	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	131,155	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,155,138	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,155,138	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 11:12 am

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)	2,320	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,660	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)	1,019	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	547	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	113	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)	709	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)	547	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)	1,924,154	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)	18,848	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)	491,073	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,433,081	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)	1,433,081	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)	863.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	612,080	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)	612,080	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 11:12 am

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	208,687	71	2,939.25	71	208,687	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)	680,800	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,501,567	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)	472,225	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)	472,225	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)	641	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	863.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	553,375	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 11:12 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	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	119,200	1,924,154	0.061949	553,375	34,281	90.00
91.00	Nursing School cost	0	1,924,154	0.000000	553,375	0	91.00
92.00	Allied health cost	0	1,924,154	0.000000	553,375	0	92.00
93.00	All other Medical Education	0	1,924,154	0.000000	553,375	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/23/2017 11:12 am
	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)	17,521	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,521	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)	17,521	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)	215	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)	4,409,130	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)	4,409,130	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,409,130	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: 14-1346 | Component CCN: 14-5499 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 11:12 am

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)	4,409,130	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	251.65	71.00
72.00	Program routine service cost (line 9 x line 71)	54,105	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	54,105	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	54,105	83.00
84.00	Program inpatient ancillary services (see instructions)	97,493	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)	151,598	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: 14-1346 Component CCN: 14-5499	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/23/2017 11:12 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 11:12 am

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)	2,320	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,660	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)	1,019	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	547	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	113	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)	128	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	113	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)	1,924,154	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)	18,848	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)	491,073	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,433,081	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)	1,433,081	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)	863.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	110,502	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)	110,502	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 11:12 am

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	208,687	71	2,939.25	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)	96,343	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	206,845	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)	18,848	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)	18,848	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)	641	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	863.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	553,375	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 11:12 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	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	119,200	1,924,154	0.061949	553,375	34,281	90.00
91.00	Nursing School cost	0	1,924,154	0.000000	553,375	0	91.00
92.00	Allied health cost	0	1,924,154	0.000000	553,375	0	92.00
93.00	All other Medical Education	0	1,924,154	0.000000	553,375	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 11:12 am

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		779,901		30.00
31.00	03100	INTENSIVE CARE UNIT		91,377		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.566227	67,477	38,207	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131980	169,287	22,342	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272000	51,292	13,951	55.00
60.00	06000	LABORATORY	0.160079	575,713	92,160	60.00
65.00	06500	RESPIRATORY THERAPY	0.237849	274,867	65,377	65.00
66.00	06600	PHYSICAL THERAPY	0.461396	50,469	23,286	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465002	5,155	2,397	67.00
68.00	06800	SPEECH PATHOLOGY	1.003946	2,470	2,480	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.378648	495,213	187,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.383465	151,806	58,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276986	629,974	174,494	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	0.441278	0	0	90.00
90.01	09002	WOUND CARE	0.212047	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.095765	0	0	90.02
90.03	09001	NEUROLOGY	2.679243	0	0	90.03
90.04	09004	DR SKOW	3.368236	0	0	90.04
90.05	09005	DR BLASER	1.704458	0	0	90.05
91.00	09100	EMERGENCY	0.362324	1,057	383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320063	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)		2,474,780	680,800	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)		2,474,780		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3

Component CCN: 14-Z346 | Date/Time Prepared: 5/23/2017 11:12 am

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	0.566227	2,739	1,551	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131980	33,188	4,380	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272000	0	0	55.00
60.00	06000	LABORATORY	0.160079	120,010	19,211	60.00
65.00	06500	RESPIRATORY THERAPY	0.237849	97,560	23,205	65.00
66.00	06600	PHYSICAL THERAPY	0.461396	93,952	43,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465002	29,443	13,691	67.00
68.00	06800	SPEECH PATHOLOGY	1.003946	4,054	4,070	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.378648	137,779	52,170	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.383465	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276986	363,276	100,622	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	0.441278	0	0	90.00
90.01	09002	WOUND CARE	0.212047	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.095765	0	0	90.02
90.03	09001	NEUROLOGY	2.679243	0	0	90.03
90.04	09004	DR SKOW	3.368236	0	0	90.04
90.05	09005	DR BLASER	1.704458	0	0	90.05
91.00	09100	EMERGENCY	0.362324	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320063	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)		882,001	262,249	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)		882,001		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1346 | Component CCN: 14-5499 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 11:12 am

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	0.566227	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131980	11,440	1,510	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272000	0	0	55.00
60.00	06000	LABORATORY	0.160079	12,933	2,070	60.00
65.00	06500	RESPIRATORY THERAPY	0.237849	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.461396	70,655	32,600	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465002	28,254	13,138	67.00
68.00	06800	SPEECH PATHOLOGY	1.003946	2,003	2,011	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.378648	7,926	3,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.383465	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276986	155,830	43,163	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	0.441278	0	0	90.00
90.01	09002	WOUND CARE	0.212047	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.095765	0	0	90.02
90.03	09001	NEUROLOGY	2.679243	0	0	90.03
90.04	09004	DR SKOW	3.368236	0	0	90.04
90.05	09005	DR BLASER	1.704458	0	0	90.05
91.00	09100	EMERGENCY	0.362324	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320063	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)		289,041	97,493	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)		289,041		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 11:12 am

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		118,322		30.00
31.00	03100	INTENSIVE CARE UNIT		13,793		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.566227	7,337	4,154	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131980	46,504	6,138	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.272000	0	0	55.00
60.00	06000	LABORATORY	0.160079	104,691	16,759	60.00
65.00	06500	RESPIRATORY THERAPY	0.237849	48,747	11,594	65.00
66.00	06600	PHYSICAL THERAPY	0.461396	2,597	1,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.465002	640	298	67.00
68.00	06800	SPEECH PATHOLOGY	1.003946	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.378648	78,272	29,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.383465	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276986	93,888	26,006	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC) VANDALIA	2.349007	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC) ST ELMO	1.248653	0	0	88.01
90.00	09000	CLINIC	0.441278	0	0	90.00
90.01	09002	WOUND CARE	0.212047	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.095765	0	0	90.02
90.03	09001	NEUROLOGY	2.679243	0	0	90.03
90.04	09004	DR SKOW	3.368236	0	0	90.04
90.05	09005	DR BLASER	1.704458	0	0	90.05
91.00	09100	EMERGENCY	0.362324	1,541	558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.320063	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)		384,217	96,343	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)		384,217		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1346	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/23/2017 11:12 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,099,343	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)	6,099,343	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)	6,160,336	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)	41,369	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,570,145	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)	2,548,822	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)	2,548,822	30.00
31.00	Primary payer payments	499	31.00
32.00	Subtotal (line 30 minus line 31)	2,548,323	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)	1,039,945	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	675,964	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	775,037	36.00
37.00	Subtotal (see instructions)	3,224,287	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)	3,224,287	40.00
40.01	Sequestration adjustment (see instructions)	64,486	40.01
41.00	Interim payments	2,950,111	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	209,690	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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/23/2017 11:12 am

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		1,119,154		2,950,111	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	07/11/2016	55,600		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)		55,600		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)		1,174,754		2,950,111	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		51,995		209,690	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,226,749		3,159,801	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: 14-1346 | Component CCN: 14-Z346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2017 11:12 am

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		623,147		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	07/11/2016	49,500		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)		49,500		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)		672,647		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		48,655		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		721,302		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: 14-1346 | Component CCN: 14-5499 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2017 11:12 am

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		99,513		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)		99,513		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)		99,513		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: 14-1346	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/23/2017 11:12 am
	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	372	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	780	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,090	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	66,935,348	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	126,896	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: 14-1346 | Component CCN: 14-Z346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-2 | Date/Time Prepared: 5/23/2017 11:12 am

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)	476,947	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)	264,871	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	547	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)	741,818	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	741,818	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)	741,818	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,796	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)	736,022	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)	736,022	0	19.00
19.01	Sequestration adjustment (see instructions)	14,720	0	19.01
20.00	Interim payments	672,647	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)	48,655	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: 14-1346	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/23/2017 11:12 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,501,567	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)	1,501,567	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,516,583	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)	1,516,583	19.00
20.00	Deductibles (exclude professional component)	266,616	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,249,967	22.00
23.00	Coinsurance	1,288	23.00
24.00	Subtotal (line 22 minus line 23)	1,248,679	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,779	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,106	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,595	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,251,785	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)	1,251,785	30.00
30.01	Sequestration adjustment (see instructions)	25,036	30.01
31.00	Interim payments	1,174,754	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)	51,995	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: 14-1346 Component CCN: 14-5499	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VI Date/Time Prepared: 5/23/2017 11:12 am
	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)	113,297	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)	113,297	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	11,753	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)	101,544	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	101,544	15.00
15.01	Sequestration adjustment (see instructions)	2,031	15.01
16.00	Interim payments	99,513	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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-3 Part VII Date/Time Prepared: 5/23/2017 11:12 am

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	206,845		1.00
2.00	Medical and other services		3,155,138	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	206,845	3,155,138	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)	206,845	3,155,138	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	384,217	13,199,003	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)	384,217	13,199,003	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)	384,217	13,199,003	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	177,372	10,043,865	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)	206,845	3,155,138	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)	206,845	3,155,138	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)	206,845	3,155,138	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)	206,845	3,155,138	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	206,845	3,155,138	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)	206,845	3,155,138	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	206,845	3,155,138	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: 14-1346 Component CCN: 14-5499	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2017 11:12 am
	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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/23/2017 11:12 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,990,580	0	0	0	1.00
2.00	Temporary investments	3,630,400	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,995,001	0	0	0	4.00
5.00	Other receivable	614,300	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,103,075	0	0	0	6.00
7.00	Inventory	295,399	0	0	0	7.00
8.00	Prepaid expenses	109,645	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	16,667	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,548,917	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	35,335,777	0	0	0	19.00
20.00	Accumulated depreciation	-22,506,128	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)	12,829,649	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	5,385	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,385	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,383,951	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,530,615	0	0	0	37.00
38.00	Salaries, wages, and fees payable	933,725	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	3,968,502	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,432,842	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,778,259	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)	2,778,259	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,211,101	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	16,172,850				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)	16,172,850	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,383,951	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/23/2017 11:12 am

		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		17,836,338		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,656,910				2.00
3.00	Total (sum of line 1 and line 2)		16,179,428		0		3.00
4.00	RESTRICTED FUNDS	962		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)		962		0		10.00
11.00	Subtotal (line 3 plus line 10)		16,180,390		0		11.00
12.00	OTHER FUND BALANCE CHANGES	7,540		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)		7,540		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,172,850		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	RESTRICTED FUNDS		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	OTHER FUND BALANCE CHANGES		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: 14-1346 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/23/2017 11:12 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,726,585		1,726,585	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,355,387		3,355,387	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)	5,081,972		5,081,972	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	97,000		97,000	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)	97,000		97,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,178,972		5,178,972	17.00
18.00	Ancillary services	5,523,862	56,273,144	61,797,006	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC (RHC) VANDALIA	0	322,817	322,817	20.00
20.01	RURAL HEALTH CLINIC (RHC) ST ELMO	0	287,992	287,992	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	1,446,964	1,446,964	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	281,500	1,987,206	2,268,706	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,984,334	60,318,123	71,302,457	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,556,929		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	151,994			37.00
38.00	PHYSICIAN EXPENSE	3,161,064			38.00
39.00	340B EXPENSE	150,916			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		3,463,974		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,092,955		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1346	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/23/2017 11:12 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,302,457	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,270,980	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,031,477	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,092,955	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,061,478	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	224,371	24.00
25.00	Total other income (sum of lines 6-24)	224,371	25.00
26.00	Total (line 5 plus line 25)	-1,837,107	26.00
27.00	OTHER EXPENSES	-180,197	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-180,197	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,656,910	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346 | Component CCN: 14-8527 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/23/2017 11:12 am

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	240,179	0	240,179	0	240,179	1.00
2.00	Physician Assistant	60,466	0	60,466	0	60,466	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	124,001	0	124,001	0	124,001	9.00
10.00	Subtotal (sum of lines 1 through 9)	424,646	0	424,646	0	424,646	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	90,925	90,925	184	91,109	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	90,925	90,925	184	91,109	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	424,646	90,925	515,571	184	515,755	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
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
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						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)	424,646	90,925	515,571	184	515,755	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346 | Component CCN: 14-8527 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/23/2017 11:12 am

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	240,179		1.00
2.00	Physician Assistant	0	60,466		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	124,001		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	424,646		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	91,109		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	91,109		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	515,755		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				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	515,755		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346 | Component CCN: 14-8528 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/23/2017 11:12 am

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	44,615	0	44,615	0	44,615	1.00
2.00	Physician Assistant	63,769	0	63,769	0	63,769	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	47,098	0	47,098	0	47,098	9.00
10.00	Subtotal (sum of lines 1 through 9)	155,482	0	155,482	0	155,482	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	71,235	71,235	0	71,235	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	71,235	71,235	0	71,235	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	155,482	71,235	226,717	0	226,717	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
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
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						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)	155,482	71,235	226,717	0	226,717	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346 | Component CCN: 14-8528 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-1 | Date/Time Prepared: 5/23/2017 11:12 am

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	44,615		1.00
2.00	Physician Assistant	0	63,769		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	47,098		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	155,482		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	71,235		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	71,235		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	226,717		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				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	226,717		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1346 | Component CCN: 14-8527 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-2 | Date/Time Prepared: 5/23/2017 11:12 am

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	0.82	1,118	4,200	3,444		1.00
2.00	Physician Assistant	0.41	1,176	2,100	861		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.23	2,294		4,305	4,305	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.23	2,294			4,305	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					515,755	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)					515,755	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					325,758	15.00
16.00	Total overhead (sum of lines 14 and 15)					325,758	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					325,758	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					325,758	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					841,513	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1346 | Component CCN: 14-8528 | Period: From 01/01/2016 To 12/31/2016 | Worksheet M-2 | Date/Time Prepared: 5/23/2017 11:12 am

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	0.23	259	4,200	966		1.00
2.00	Physician Assistant	0.41	1,116	2,100	861		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.64	1,375		1,827	1,827	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)	0.64	1,375			1,827	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					226,717	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)					226,717	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					132,885	15.00
16.00	Total overhead (sum of lines 14 and 15)					132,885	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					132,885	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					132,885	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					359,602	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1346 Component CCN: 14-8527	Period: From 01/01/2016 To 12/31/2016	Worksheet M-3 Date/Time Prepared: 5/23/2017 11:12 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		841,513	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)		841,513	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,305	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,305	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		195.47	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or 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)	0.00	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	195.47	195.47	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	737	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	144,061	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)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	144,061	16.00
16.01	Total program charges (see instructions)(from contractor's records)		146,059	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		185	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		183	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.)		103,470	16.04
16.05	Total program cost (see instructions)	0	103,653	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,541	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		26,267	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		103,653	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)		103,653	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)		105,849	26.00
26.01	Sequestration adjustment (see instructions)		2,117	26.01
27.00	Interim payments		142,756	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		-39,024	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 HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1346 Component CCN: 14-8528	Period: From 01/01/2016 To 12/31/2016	Worksheet M-3 Date/Time Prepared: 5/23/2017 11:12 am
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		359,602	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)		359,602	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,827	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)		1,827	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		196.83	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or 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	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	196.83	196.83	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	334	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	65,741	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)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	65,741	16.00
16.01	Total program charges (see instructions)(from contractor's records)		66,233	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,262	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,230	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.)		42,345	16.04
16.05	Total program cost (see instructions)	0	46,575	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,580	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,678	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		46,575	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)		46,575	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)		47,519	26.00
26.01	Sequestration adjustment (see instructions)		950	26.01
27.00	Interim payments		30,867	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)		15,702	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: 14-1346 Component CCN: 14-8527	Period: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/23/2017 11:12 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		105,156	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		07/11/2016	37,600	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)		37,600	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		142,756	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		39,024	6.02
7.00	Total Medicare program liability (see instructions)		103,732	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: 14-1346 Component CCN: 14-8528	Period: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/23/2017 11:12 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		30,867	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)		30,867	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		15,702	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		46,569	7.00

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