

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet S Parts I-III Date/Time Prepared: 12/20/2019 9:35 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 12/20/2019	Time: 9:35 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ 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. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ 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 CHIEF FINANCIAL 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 CARLINVILLE AREA HOSPITAL (14-1347) for the cost reporting period beginning 08/01/2018 and ending 07/31/2019 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.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
	1.00	2.00	3.00	4.00	5.00		
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	-75,790	143,481	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	50,638	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RHC - CARLINVILLE I	0		-58,414		0	10.00
10.01	RHC - GIRARD II	0		6,111		0	10.01
200.00	Total	0	-25,152	91,178	0	0	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: 14-1347		Period: From 08/01/2018 To 07/31/2019		Worksheet S-2 Part I Date/Time Prepared: 12/20/2019 9:35 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 20733 NORTH BROAD STREET			PO Box:				1.00	
2.00	City: CARLINVILLE			State: IL		Zip Code: 62626-		County: MACOUPIN	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		CARLINVILLE AREA HOSPITAL	141347	41180	1	07/01/2005	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		CARLINVILLE AREA HOSPITAL SWING BED	14Z347	99914		07/01/2005	N	O
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		CARLINVILLE RHC	148530	99914		11/25/2013	N	O
15.01	Hospital-Based Health Clinic - RHC		GIRARD RHC	148532	99914		02/12/2014	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						08/01/2018	07/31/2019	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	3.00
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		
22.01	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		
22.02	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		
22.03	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	N	
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet S-2
Part I
Date/Time Prepared:
12/20/2019 9:35 am

	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	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							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 1.00	Y/N 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)(i), (ii), or (iii)? 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)(i), (ii), or (iii)? 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 1.00	XVIII 2.00	XIX 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
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
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
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.							
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.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347		Period: From 08/01/2018 To 07/31/2019		Worksheet S-2 Part I Date/Time Prepared: 12/20/2019 9:35 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (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
61.01	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)						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)						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)						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).						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)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						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. Enter in column 4, the 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. Enter in column 4, the 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 through 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
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To 07/31/2019Worksheet S-2
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	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	
			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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	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 is 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 is 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

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				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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? 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	N	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	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	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.		Y		108.00
			Physical	Occupational	
			1.00	2.00	
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	109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

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		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	257,108	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 healthcare related taxes as defined in §1903(w)(3) of the Act? 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
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)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1347		Period: From 08/01/2018 To 07/31/2019		Worksheet S-2 Part I Date/Time Prepared: 12/20/2019 9:35 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							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	Y	Y	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		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2017	09/30/2018		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: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet S-2 Part II Date/Time Prepared: 12/20/2019 9:35 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	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for 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
			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	11/01/2019	Y	11/01/2019
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet S-2
Part II
Date/Time Prepared:
12/20/2019 9:35 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		Y		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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	MICHAEL	BROWN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CARLINVILLE AREA HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-854-3141	MBROWN@CAHCARE.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet S-2 Part II Date/Time Prepared: 12/20/2019 9:35 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.	CFO		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: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet S-3
Part I
Date/Time Prepared:
12/20/2019 9:35 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	25	9,125	25,296.00	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)		25	9,125	25,296.00	0	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)		25	9,125	25,296.00	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						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	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC - CARLINVILLE	88.00				0	26.00
26.01 RHC - GIRARD	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				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
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet S-3
Part I
Date/Time Prepared:
12/20/2019 9:35 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)	695	99	1,054			1.00
2.00	HMO and other (see instructions)	8	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,128	0	1,347			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	54			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,823	99	2,455			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)	1,823	99	2,455	0.00	152.51	14.00
15.00	CAH visits	14,005	3,999	26,228			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	2,349	3,764	12,041	0.00	20.12	26.00
26.01	RHC - GIRARD	449	648	1,964	0.00	2.78	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	175.41	27.00
28.00	Observation Bed Days		54	429			28.00
29.00	Ambulance Trips	0					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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet S-3
Part I
Date/Time Prepared:
12/20/2019 9:35 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	233	36	362	1.00
2.00 HMO and other (see instructions)			2	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	233	36	362	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						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	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC - CARLINVILLE	0.00					26.00
26.01 RHC - GIRARD	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			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		CARLINVILLE AREA HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1347 Component CCN: 14-8530		Period: From 08/01/2018 To 07/31/2019 Worksheet S-8 Date/Time Prepared: 12/20/2019 9:35 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1115 EAST MORGAN STREET, #2		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CARLINVILLE IL 62626		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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		11.00	
		07:30		16:00	
		07:30		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		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	MACOUPIN		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	16:00	07:30	16:00	07:30
		16:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2018 To 07/31/2019	Worksheet S-8 Date/Time Prepared: 12/20/2019 9:35 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	07:30	16:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1347
 Component CCN: 14-8532

 Period:
 From 08/01/2018
 To 07/31/2019

Worksheet S-8

 Date/Time Prepared:
 12/20/2019 9:35 am

				RHC II		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			205 SOUTH THRID STREET			1.00
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			GIRARD IL 62640		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		17:00	08:00
				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			MACOUPIN		2.00	
			Tuesday		Wednesday		Thursday
			to	from	to	from	to
			6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)							
11.00	CLINIC			17:00	08:00	17:00	08:00
				17:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1347

Period:

Worksheet S-8

Component CCN: 14-8532

From 08/01/2018
To 07/31/2019

Date/Time Prepared:

12/20/2019 9:35 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet S-10 Date/Time Prepared: 12/20/2019 9:35 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)		0.490492	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,941,316	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 and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,944,584	5.00
6.00	Medicaid charges		9,654,725	6.00
7.00	Medicaid cost (line 1 times line 6)		4,735,565	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
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (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		20,296	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
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	200,470	0	200,470 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	98,329	0	98,329 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	98,329	0	98,329 23.00
			1.00	
24.00	Does the amount on 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, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		896,255	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		304,434	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		468,360	27.01
28.00	Non-Medicare bad debt expense (see instructions)		427,895	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		373,805	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		472,134	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		472,134	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet A

Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		1,686,827	1,686,827	736,950	2,423,777	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		543,980	543,980	16,900	560,880	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,735,037	2,735,037	0	2,735,037	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,375,454	2,771,376	4,146,830	123,587	4,270,417	5.00
7.00	00700	OPERATION OF PLANT	251,556	450,706	702,262	0	702,262	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	281,313	281,313	0	281,313	8.00
9.00	00900	HOUSEKEEPING	299,623	43,399	343,022	0	343,022	9.00
10.00	01000	DIETARY	188,120	237,400	425,520	0	425,520	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	327,356	17,322	344,678	0	344,678	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	205,128	73,371	278,499	0	278,499	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	193,661	6,982	200,643	0	200,643	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	995,163	273,123	1,268,286	0	1,268,286	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	587,755	647,762	1,235,517	0	1,235,517	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	503,556	962,380	1,465,936	4,790	1,470,726	54.00
60.00	06000	LABORATORY	573,497	718,975	1,292,472	0	1,292,472	60.00
65.00	06500	RESPIRATORY THERAPY	334,590	215,820	550,410	0	550,410	65.00
66.00	06600	PHYSICAL THERAPY	982,566	75,810	1,058,376	0	1,058,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,029	5,866	224,895	0	224,895	67.00
69.00	06900	ELECTROCARDIOLOGY	101,642	119,321	220,963	0	220,963	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,926	199,246	289,172	0	289,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,740	47,740	0	47,740	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	228,045	1,018,590	1,246,635	0	1,246,635	73.00
76.00	03550	BEHAVIORIAL HEALTH	135,724	106,815	242,539	0	242,539	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	1,626,469	260,141	1,886,610	-165,277	1,721,333	88.00
88.01	08801	RHC - GIRARD	263,341	56,883	320,224	-35,674	284,550	88.01
90.00	09000	CLINIC	268,679	157,517	426,196	0	426,196	90.00
91.00	09100	EMERGENCY	1,280,647	1,811,469	3,092,116	0	3,092,116	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								
113.00	11300	INTEREST EXPENSE		681,276	681,276	-681,276	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,031,527	16,206,447	27,237,974	0	27,237,974	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	99,775	99,775	0	99,775	194.00
194.01	07951	FUND DEVELOPMENT	15,189	0	15,189	0	15,189	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	11,046,716	16,306,222	27,352,938	0	27,352,938	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet A

Date/Time Prepared:
12/20/2019 9:35 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	-174,820	2,248,957	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-1,550	559,330	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,735,037	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-235,072	4,035,345	5.00
7.00	00700	OPERATION OF PLANT	-26	702,236	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	281,313	8.00
9.00	00900	HOUSEKEEPING	0	343,022	9.00
10.00	01000	DIETARY	-75,789	349,731	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	344,678	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,719	272,780	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	200,643	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,268,286	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-445,225	790,292	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-25,512	1,445,214	54.00
60.00	06000	LABORATORY	-300	1,292,172	60.00
65.00	06500	RESPIRATORY THERAPY	0	550,410	65.00
66.00	06600	PHYSICAL THERAPY	-8,353	1,050,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	224,895	67.00
69.00	06900	ELECTROCARDIOLOGY	-44,590	176,373	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	289,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,740	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-163,274	1,083,361	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	242,539	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	1,721,333	88.00
88.01	08801	RHC - GIRARD	0	284,550	88.01
90.00	09000	CLINIC	-44,046	382,150	90.00
91.00	09100	EMERGENCY	-1,275,624	1,816,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,499,900	24,738,074	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	99,775	194.00
194.01	07951	FUND DEVELOPMENT	0	15,189	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,499,900	24,853,038	200.00

RECLASSIFICATIONS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet A-6

Date/Time Prepared:
12/20/2019 9:35 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - RECLASS RECRUITMENT EXPENSES					
1.00 RHC - CARLINVILLE	88.00	0	12,685		1.00
TOTALS		0	12,685		
B - RECLASS PHYSICIAN SALARY EXPENSE					
1.00	0.00	0	0		1.00
TOTALS		0	0		
C - INSURANCE EXPENSE					
1.00 OTHER CAPITAL RELATED COSTS	3.00	0	77,364		1.00
TOTALS		0	77,364		
E - INTEREST EXPENSE RECLASS					
1.00 RADIOLOGY-DIAGNOSTIC	54.00	0	4,790		1.00
2.00 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	676,486		2.00
TOTALS		0	681,276		
L - RECLASS RHC ADMIN SALARIES TO ADMIN					
1.00 ADMINISTRATIVE & GENERAL	5.00	213,636	0		1.00
2.00	0.00	0	0		2.00
TOTALS		213,636	0		
500.00 Grand Total: Increases		213,636	771,325		500.00

RECLASSIFICATIONS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet A-6
Date/Time Prepared:
12/20/2019 9:35 am

		Decreases				Wkst. A-7 Ref.		
		Cost Center	Line #	Salary	Other			
		6.00	7.00	8.00	9.00	10.00		
A - RECLASS RECRUITMENT EXPENSES								
1.00		ADMINISTRATIVE & GENERAL	5.00	0	12,685	0		1.00
		TOTALS		0	12,685			
B - RECLASS PHYSICIAN SALARY EXPENSE								
1.00			0.00	0	0	0		1.00
		TOTALS		0	0			
C - INSURANCE EXPENSE								
1.00		ADMINISTRATIVE & GENERAL	5.00	0	77,364	0		1.00
		TOTALS		0	77,364			
E - INTEREST EXPENSE RECLASS								
1.00		INTEREST EXPENSE	113.00	0	681,276	9		1.00
2.00			0.00	0	0	9		2.00
		TOTALS		0	681,276			
L - RECLASS RHC ADMIN SALARIES TO ADMIN								
1.00		RHC - CARLINVILLE	88.00	177,962	0	0		1.00
2.00		RHC - GIRARD	88.01	35,674	0	0		2.00
		TOTALS		213,636	0			
500.00		Grand Total: Decreases		213,636	771,325			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet A-7
Part I
Date/Time Prepared:
12/20/2019 9:35 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	500,172	0	0	0	0	1.00	
2.00	Land Improvements	2,432,796	0	0	0	0	2.00	
3.00	Buildings and Fixtures	25,859,764	2,345,255	0	2,345,255	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	6,901,935	619,547	0	619,547	0	6.00	
7.00	HIT designated Assets	1,180,327	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	36,874,994	2,964,802	0	2,964,802	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	36,874,994	2,964,802	0	2,964,802	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	500,172	0				1.00	
2.00	Land Improvements	2,432,796	0				2.00	
3.00	Buildings and Fixtures	28,205,019	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	7,521,482	0				6.00	
7.00	HIT designated Assets	1,180,327	0				7.00	
8.00	Subtotal (sum of lines 1-7)	39,839,796	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	39,839,796	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet A-7
Part II
Date/Time Prepared:
12/20/2019 9:35 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	1,686,827	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	543,980	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,230,807	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	1,686,827				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	543,980				2.00
3.00	Total (sum of lines 1-2)	0	2,230,807				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet A-7
Part III
Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	31,137,987	0	31,137,987	0.781558	60,464	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,702,944	0	8,702,944	0.218442	16,900	2.00
3.00	Total (sum of lines 1-2)	39,840,931	0	39,840,931	1.000000	77,364	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	60,464	2,188,493	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	16,900	542,430	0	2.00
3.00	Total (sum of lines 1-2)	0	0	77,364	2,730,923	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	60,464	0	0	2,248,957	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	16,900	0	0	559,330	2.00
3.00	Total (sum of lines 1-2)	0	77,364	0	0	2,808,287	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet A-8

Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-17,018	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-3,070	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,387	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	-1,715,965			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-75,784	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	B	-38,196	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,719	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - 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		0	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	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet A-8

Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-1,550	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	DIETARY DISCOUNTS	B	-5	DIETARY	10.00	0	33.00
33.01	RADIOLOGY DISCOUNTS	B	-25,512	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	PT PROF FEES	B	-625	PHYSICAL THERAPY	66.00	0	33.02
33.03	PREVIOUS DEBT ISSUANCE COSTS	A	43,119	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.03
33.04	CONTRACT LAB	B	0	LABORATORY	60.00	0	33.04
33.05	SUPPLIES	B	-4,884	OPERATING ROOM	50.00	0	33.05
33.06	AHA & IHA DUES	A	-9,409	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PLANT OPERATION DISCOUNTS	B	-26	OPERATION OF PLANT	7.00	0	33.07
36.00	ACQUATIC THERAPY	B	-7,728	PHYSICAL THERAPY	66.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
39.00	MED STAFF RELATIONS	A	-5,572	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
41.00	NON-PATIENT REVENUE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING	A	-208,689	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	TELEPHONE DEPRECIATION	A	-2,150	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-2,072	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-44,046	CLINIC	90.00	0	44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,916	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	INSURANCE PROCEEDS	A	-957	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05	MOB BUILDING RENT	B	-198,771	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.05
44.06	PHARMACY DISCOUNTS	B	-5	DRUGS CHARGED TO PATIENTS	73.00	0	44.06
44.07	SALE OF LABS	B	-300	LABORATORY	60.00	0	44.07
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
45.01	340B PROGRAM	B	-125,073	DRUGS CHARGED TO PATIENTS	73.00	0	45.01
45.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.02
45.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.03
45.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.04
45.05	EKG PROFESSIONAL FEES	A	-44,590	ELECTROCARDIOLOGY	69.00	0	45.05
45.06	SLEEP STUDY PROFESSIONAL FEES	A	0	RESPIRATORY THERAPY	65.00	0	45.06
45.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.07
45.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.08
45.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,499,900				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet A-8-2

Date/Time Prepared:
12/20/2019 9:35 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	1,700,000	810,390	889,610	0	0	1.00
2.00	91.00	EMERGENCY	410,612	410,612	0	0	0	2.00
3.00	50.00	OPERATING ROOM	440,341	440,341	0	0	0	3.00
4.00	91.00	EMERGENCY	54,622	54,622	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,605,575	1,715,965	889,610			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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	810,390		1.00
2.00	91.00	EMERGENCY	0	0	0	410,612		2.00
3.00	50.00	OPERATING ROOM	0	0	0	440,341		3.00
4.00	91.00	EMERGENCY	0	0	0	54,622		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,715,965		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1347		Period: From 08/01/2018 To 07/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/20/2019 9:35 am	
				Respiratory Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					38	1.00
2.00	Line 1 multiplied by 15 hours per week					570	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.55	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,637.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	65.82	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.91	32.91	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					107,764	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					107,764	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					107,764	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					107,764	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1347		Period: From 08/01/2018 To 07/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/20/2019 9:35 am		
				Respiratory Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	65.82	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						107,764	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						107,764	63.00
64.00	Total cost of outside supplier services (from your records)						97,094	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,248,957	2,248,957			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	559,330	559,330			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,735,037	0	2,735,037		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,035,345	483,285	177,160	393,443	5,089,233
7.00	00700	OPERATION OF PLANT	702,236	259,135	23,499	62,282	1,047,152
8.00	00800	LAUNDRY & LINEN SERVICE	281,313	0	0	0	281,313
9.00	00900	HOUSEKEEPING	343,022	10,591	19	74,183	427,815
10.00	01000	DIETARY	349,731	40,776	17,782	46,576	454,865
11.00	01100	CAFETERIA	0	41,088	0	0	41,088
13.00	01300	NURSING ADMINISTRATION	344,678	6,730	664	81,049	433,121
16.00	01600	MEDICAL RECORDS & LIBRARY	272,780	30,354	4,956	50,787	358,877
19.00	01900	NONPHYSICIAN ANESTHETISTS	200,643	2,243	13,585	47,948	264,419
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,268,286	318,253	53,045	246,390	1,885,974
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	790,292	149,359	43,157	145,521	1,128,329
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,445,214	100,292	92,591	124,674	1,762,771
60.00	06000	LABORATORY	1,292,172	41,826	23,849	141,991	1,499,838
65.00	06500	RESPIRATORY THERAPY	550,410	90,751	23,902	82,840	747,903
66.00	06600	PHYSICAL THERAPY	1,050,023	185,336	27,930	243,272	1,506,561
67.00	06700	OCCUPATIONAL THERAPY	224,895	14,056	0	54,229	293,180
69.00	06900	ELECTROCARDIOLOGY	176,373	85,952	10,782	25,165	298,272
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	289,172	23,483	1,055	22,265	335,975
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,740	0	0	0	47,740
73.00	07300	DRUGS CHARGED TO PATIENTS	1,083,361	18,287	11,116	56,461	1,169,225
76.00	03550	BEHAVIORIAL HEALTH	242,539	37,425	998	33,604	314,566
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	1,721,333	167,617	17,605	358,633	2,265,188
88.01	08801	RHC - GIRARD	284,550	0	0	56,368	340,918
90.00	09000	CLINIC	382,150	72,493	1,991	66,522	523,156
91.00	09100	EMERGENCY	1,816,492	62,697	13,311	317,073	2,209,573
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,738,074	2,242,029	558,997	2,731,276	24,727,052
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,196	20	0	5,216
194.00	07950	NONREIMBURSABLE COSTS CENTERS	99,775	0	0	0	99,775
194.01	07951	FUND DEVELOPMENT	15,189	1,732	313	3,761	20,995
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	24,853,038	2,248,957	559,330	2,735,037	24,853,038

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
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	5,089,233					5.00
7.00	00700	OPERATION OF PLANT	269,645	1,316,797				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,439	0	353,752			8.00
9.00	00900	HOUSEKEEPING	110,164	9,257	0	547,236		9.00
10.00	01000	DIETARY	117,129	35,640	0	14,251	621,885	10.00
11.00	01100	CAFETERIA	10,580	35,913	0	14,360	395,487	11.00
13.00	01300	NURSING ADMINISTRATION	111,530	5,882	0	2,352	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	92,412	26,532	0	10,609	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	68,089	1,961	0	784	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	485,644	278,172	166,421	111,234	226,398	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	290,548	130,548	29,408	52,202	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	453,919	87,661	32,494	35,053	0	54.00
60.00	06000	LABORATORY	386,213	36,558	0	14,618	0	60.00
65.00	06500	RESPIRATORY THERAPY	192,587	79,322	2,473	31,718	0	65.00
66.00	06600	PHYSICAL THERAPY	387,944	161,994	28,975	64,776	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	75,495	12,285	0	4,913	0	67.00
69.00	06900	ELECTROCARDIOLOGY	76,806	75,127	0	30,239	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	86,515	20,525	0	8,207	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,293	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,079	15,983	0	6,391	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	81,002	32,711	0	13,080	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	583,286	146,507	200	58,583	0	88.00
88.01	08801	RHC - GIRARD	87,787	0	0	27,173	0	88.01
90.00	09000	CLINIC	134,714	63,363	0	22,359	0	90.00
91.00	09100	EMERGENCY	568,972	54,800	93,781	21,913	0	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								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,056,792	1,310,741	353,752	544,815	621,885	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,343	4,542	0	1,816	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	25,692	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	5,406	1,514	0	605	0	194.01
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 through 201)	5,089,233	1,316,797	353,752	547,236	621,885	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		11.00	13.00	16.00	19.00	24.00	
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
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	497,428				11.00
13.00	01300	NURSING ADMINISTRATION	13,821	566,706			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,740	0	513,170		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,962	9,594	9,138	357,947	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	100,159	242,212	27,149	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	28,979	70,032	41,684	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	357,947	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,450	0	127,846	0	54.00
60.00	06000	LABORATORY	53,028	0	96,191	0	60.00
65.00	06500	RESPIRATORY THERAPY	26,675	0	11,024	0	65.00
66.00	06600	PHYSICAL THERAPY	63,025	0	53,111	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,794	0	8,883	0	67.00
69.00	06900	ELECTROCARDIOLOGY	8,707	0	11,736	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,201	0	11,792	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	884	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,683	33,085	33,369	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	11,103	26,849	2,842	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	19,507	0	88.00
88.01	08801	RHC - GIRARD	0	0	2,697	0	88.01
90.00	09000	CLINIC	22,897	55,354	4,090	0	90.00
91.00	09100	EMERGENCY	61,597	129,580	51,227	0	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	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	492,821	566,706	513,170	357,947	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	4,607	0	0	0	194.01
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 through 201)	497,428	566,706	513,170	357,947	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	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
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
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	0	3,523,363	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,771,730	50.00
53.00	05300	ANESTHESIOLOGY	0	357,947	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,540,194	54.00
60.00	06000	LABORATORY	0	2,086,446	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,091,702	65.00
66.00	06600	PHYSICAL THERAPY	0	2,266,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	406,550	67.00
69.00	06900	ELECTROCARDIOLOGY	0	500,887	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	471,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	60,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,572,815	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	482,153	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	3,073,271	88.00
88.01	08801	RHC - GIRARD	0	458,575	88.01
90.00	09000	CLINIC	0	825,933	90.00
91.00	09100	EMERGENCY	0	3,191,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	24,681,527	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,917	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	125,467	194.00
194.01	07951	FUND DEVELOPMENT	0	33,127	194.01
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	24,853,038	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		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	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,456	483,285	177,160	704,901	0 5.00
7.00	00700	OPERATION OF PLANT	0	259,135	23,499	282,634	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	0	10,591	19	10,610	0 9.00
10.00	01000	DIETARY	1,821	40,776	17,782	60,379	0 10.00
11.00	01100	CAFETERIA	0	41,088	0	41,088	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	6,730	664	7,394	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,354	4,956	35,310	0 16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,243	13,585	15,828	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,606	318,253	53,045	390,904	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	304,276	149,359	43,157	496,792	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,178	100,292	92,591	279,061	0 54.00
60.00	06000	LABORATORY	19,476	41,826	23,849	85,151	0 60.00
65.00	06500	RESPIRATORY THERAPY	18,893	90,751	23,902	133,546	0 65.00
66.00	06600	PHYSICAL THERAPY	0	185,336	27,930	213,266	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,056	0	14,056	0 67.00
69.00	06900	ELECTROCARDIOLOGY	0	85,952	10,782	96,734	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,483	1,055	24,538	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,751	18,287	11,116	117,154	0 73.00
76.00	03550	BEHAVIORIAL HEALTH	0	37,425	998	38,423	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	167,617	17,605	185,222	0 88.00
88.01	08801	RHC - GIRARD	25,638	0	0	25,638	0 88.01
90.00	09000	CLINIC	0	72,493	1,991	74,484	0 90.00
91.00	09100	EMERGENCY	0	62,697	13,311	76,008	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	0	0	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0 113.00
116.00	11600	HOSPICE	0	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	608,095	2,242,029	558,997	3,409,121	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,196	20	5,216	0 190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0 194.00
194.01	07951	FUND DEVELOPMENT	0	1,732	313	2,045	0 194.01
200.00		Cross Foot Adjustments	0	0	0	0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	608,095	2,248,957	559,330	3,416,382	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
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	704,901					5.00
7.00	00700	OPERATION OF PLANT	37,348	319,982				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,033	0	10,033			8.00
9.00	00900	HOUSEKEEPING	15,258	2,250	0	28,118		9.00
10.00	01000	DIETARY	16,223	8,661	0	732	85,995	10.00
11.00	01100	CAFETERIA	1,465	8,727	0	738	54,688	11.00
13.00	01300	NURSING ADMINISTRATION	15,448	1,429	0	121	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,800	6,447	0	545	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	9,431	476	0	40	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,265	67,595	4,719	5,717	31,307	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,243	31,723	834	2,682	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,871	21,302	922	1,801	0	54.00
60.00	06000	LABORATORY	53,493	8,884	0	751	0	60.00
65.00	06500	RESPIRATORY THERAPY	26,675	19,275	70	1,630	0	65.00
66.00	06600	PHYSICAL THERAPY	53,733	39,364	822	3,328	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,457	2,985	0	252	0	67.00
69.00	06900	ELECTROCARDIOLOGY	10,638	18,256	0	1,554	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,983	4,988	0	422	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,703	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,702	3,884	0	328	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	11,219	7,949	0	672	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	80,794	35,601	6	3,010	0	88.00
88.01	08801	RHC - GIRARD	12,159	0	0	1,396	0	88.01
90.00	09000	CLINIC	18,659	15,397	0	1,149	0	90.00
91.00	09100	EMERGENCY	78,807	13,317	2,660	1,126	0	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								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	700,407	318,510	10,033	27,994	85,995	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	186	1,104	0	93	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	3,559	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	749	368	0	31	0	194.01
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 through 201)	704,901	319,982	10,033	28,118	85,995	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet B
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		11.00	13.00	16.00	19.00	24.00	
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
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	106,706				11.00
13.00	01300	NURSING ADMINISTRATION	2,965	27,357			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,307	0	60,409		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	850	463	1,075	28,163	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,487	11,693	3,195	603,882	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,216	3,381	4,905	586,776	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,677	0	15,068	389,702	54.00
60.00	06000	LABORATORY	11,375	0	11,319	170,973	60.00
65.00	06500	RESPIRATORY THERAPY	5,722	0	1,297	188,215	65.00
66.00	06600	PHYSICAL THERAPY	13,520	0	6,250	330,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,530	0	1,045	31,325	67.00
69.00	06900	ELECTROCARDIOLOGY	1,868	0	1,381	130,431	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,759	0	1,388	45,078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	104	1,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,935	1,597	3,927	171,527	73.00
76.00	03550	BEHAVIORIAL HEALTH	2,382	1,296	334	62,275	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	2,295	306,928	88.00
88.01	08801	RHC - GIRARD	0	0	317	39,510	88.01
90.00	09000	CLINIC	4,912	2,672	481	117,754	90.00
91.00	09100	EMERGENCY	13,213	6,255	6,028	197,414	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	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,718	27,357	60,409	0	3,373,880
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	6,599	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	3,559	194.00
194.01	07951	FUND DEVELOPMENT	988	0	0	4,181	194.01
200.00		Cross Foot Adjustments				28,163	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	106,706	27,357	60,409	28,163	3,416,382

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	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
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
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	0	603,882	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	586,776	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	389,702	54.00
60.00	06000	LABORATORY	0	170,973	60.00
65.00	06500	RESPIRATORY THERAPY	0	188,215	65.00
66.00	06600	PHYSICAL THERAPY	0	330,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	31,325	67.00
69.00	06900	ELECTROCARDIOLOGY	0	130,431	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	171,527	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	62,275	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	306,928	88.00
88.01	08801	RHC - GIRARD	0	39,510	88.01
90.00	09000	CLINIC	0	117,754	90.00
91.00	09100	EMERGENCY	0	197,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,373,880	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	6,599	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	3,559	194.00
194.01	07951	FUND DEVELOPMENT	0	4,181	194.01
200.00		Cross Foot Adjustments	0	28,163	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,416,382	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	79,202				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		502,308			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,046,716		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,020	159,100	1,589,090	-5,089,233	5.00
7.00	00700	OPERATION OF PLANT	9,126	21,103	251,556	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	373	17	299,623	0	9.00
10.00	01000	DIETARY	1,436	15,969	188,120	0	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	237	596	327,356	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	4,451	205,128	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	12,200	193,661	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,208	47,637	995,163	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,260	38,757	587,755	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	83,152	503,556	0	54.00
60.00	06000	LABORATORY	1,473	21,418	573,497	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	21,465	334,590	0	65.00
66.00	06600	PHYSICAL THERAPY	6,527	25,083	982,566	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	219,029	0	67.00
69.00	06900	ELECTROCARDIOLOGY	3,027	9,683	101,642	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	947	89,926	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	9,983	228,045	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	1,318	896	135,724	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	5,903	15,810	1,448,507	0	88.00
88.01	08801	RHC - GIRARD	0	0	227,667	0	88.01
90.00	09000	CLINIC	2,553	1,788	268,679	0	90.00
91.00	09100	EMERGENCY	2,208	11,954	1,280,647	0	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	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,958	502,009	11,031,527	-5,089,233	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	281	15,189	0	194.01
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)	2,248,957	559,330	2,735,037	5,089,233	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.395205	1.113520	0.247588	0.257503	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	704,901	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.035666	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
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	53,056				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	118,293			8.00
9.00	00900	HOUSEKEEPING	373	0	55,141		9.00
10.00	01000	DIETARY	1,436	0	1,436	27,139	10.00
11.00	01100	CAFETERIA	1,447	0	1,447	17,259	11.00
13.00	01300	NURSING ADMINISTRATION	237	0	237	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	0	1,069	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,208	55,650	11,208	9,880	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,260	9,834	5,260	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	10,866	3,532	0	54.00
60.00	06000	LABORATORY	1,473	0	1,473	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	827	3,196	0	65.00
66.00	06600	PHYSICAL THERAPY	6,527	9,689	6,527	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	495	0	67.00
69.00	06900	ELECTROCARDIOLOGY	3,027	0	3,047	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	0	827	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	0	644	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	1,318	0	1,318	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	5,903	67	5,903	0	88.00
88.01	08801	RHC - GIRARD	0	0	2,738	0	88.01
90.00	09000	CLINIC	2,553	0	2,253	0	90.00
91.00	09100	EMERGENCY	2,208	31,360	2,208	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				1,337	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,812	118,293	54,897	27,139	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	0	183	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	0	61	0	194.01
200.00		Cross Foot Adjustments				100	200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,316,797	353,752	547,236	621,885	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.819003	2.990473	9.924303	22.914809	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	319,982	10,033	28,118	85,995	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.031024	0.084815	0.509929	3.168687	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	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
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	105,788			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50,319,933		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,791	896,098	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,214	2,662,222	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,073	4,087,422	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,535,500	0	54.00
60.00	06000	LABORATORY	0	9,432,364	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,080,986	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,208,017	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	871,029	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	1,150,797	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,156,305	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	86,694	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,176	3,272,092	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	5,012	278,730	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	1,912,838	0	88.00
88.01	08801	RHC - GIRARD	0	264,477	0	88.01
90.00	09000	CLINIC	10,333	401,089	0	90.00
91.00	09100	EMERGENCY	24,189	5,023,273	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,788	50,319,933	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	194.01
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)	566,706	513,170	357,947	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.356997	0.010198	3,579.470000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,357	60,409	28,163	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.258602	0.001200	281.630000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet C
Part I
Date/Time Prepared:
12/20/2019 9:35 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,523,363		3,523,363	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,771,730		1,771,730	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	357,947		357,947	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,540,194		2,540,194	0	0	54.00	
60.00	06000	LABORATORY	2,086,446		2,086,446	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	1,091,702	0	1,091,702	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	2,266,386	0	2,266,386	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	406,550	0	406,550	0	0	67.00	
69.00	06900	ELECTROCARDIOLOGY	500,887		500,887	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	471,215		471,215	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60,917		60,917	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,572,815		1,572,815	0	0	73.00	
76.00	03550	BEHAVORIAL HEALTH	482,153		482,153	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC - CARLINVILLE	3,073,271		3,073,271	0	0	88.00	
88.01	08801	RHC - GIRARD	458,575		458,575	0	0	88.01	
90.00	09000	CLINIC	825,933		825,933	0	0	90.00	
91.00	09100	EMERGENCY	3,191,443		3,191,443	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	532,784		532,784	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0		0		0	116.00	
200.00		Subtotal (see instructions)	25,214,311	0	25,214,311	0	0	200.00	
201.00		Less Observation Beds	532,784		532,784		0	201.00	
202.00		Total (see instructions)	24,681,527	0	24,681,527	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet C
Part I
Date/Time Prepared:
12/20/2019 9:35 am

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,936,396		1,936,396			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	53,374	4,034,048	4,087,422	0.433459	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	12,362	883,736	896,098	0.399451	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	633,125	11,902,375	12,535,500	0.202640	0.000000	54.00
60.00	06000	LABORATORY	893,691	8,538,673	9,432,364	0.221201	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	278,012	802,974	1,080,986	1.009913	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	521,005	4,687,012	5,208,017	0.435173	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	373,977	497,052	871,029	0.466747	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	41,563	1,109,234	1,150,797	0.435252	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	449,100	707,205	1,156,305	0.407518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	86,694	86,694	0.702667	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,116	2,036,976	3,272,092	0.480676	0.000000	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	278,730	278,730	1.729821	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	1,912,838	1,912,838			88.00
88.01	08801	RHC - GIRARD	0	264,477	264,477			88.01
90.00	09000	CLINIC	11,603	389,486	401,089	2.059226	0.000000	90.00
91.00	09100	EMERGENCY	113,722	4,909,551	5,023,273	0.635331	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	34,692	691,134	725,826	0.734038	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	6,587,738	43,732,195	50,319,933			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,587,738	43,732,195	50,319,933			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet C
Part I
Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
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
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
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 BEHAVIORIAL HEALTH	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - CARLINVILLE				88.00
88.01	08801 RHC - GIRARD				88.01
90.00	09000 CLINIC	0.000000			90.00
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
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
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: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet D
Part II
Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description			Title XVIII		Hospital	Cost	
			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	586,776	4,087,422	0.143557	24,062	3,454
53.00	05300	ANESTHESIOLOGY	0	896,098	0.000000	6,311	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	389,702	12,535,500	0.031088	327,699	10,188
60.00	06000	LABORATORY	170,973	9,432,364	0.018126	350,276	6,349
65.00	06500	RESPIRATORY THERAPY	188,215	1,080,986	0.174114	118,836	20,691
66.00	06600	PHYSICAL THERAPY	330,283	5,208,017	0.063418	63,654	4,037
67.00	06700	OCCUPATIONAL THERAPY	31,325	871,029	0.035963	26,153	941
69.00	06900	ELECTROCARDIOLOGY	130,431	1,150,797	0.113340	20,351	2,307
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,078	1,156,305	0.038985	166,900	6,507
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,807	86,694	0.020843	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	171,527	3,272,092	0.052421	443,253	23,236
76.00	03550	BEHAVIORIAL HEALTH	62,275	278,730	0.223424	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	306,928	1,912,838	0.160457	0	0
88.01	08801	RHC - GIRARD	39,510	264,477	0.149389	0	0
90.00	09000	CLINIC	117,754	401,089	0.293586	5,328	1,564
91.00	09100	EMERGENCY	197,414	5,023,273	0.039300	12,835	504
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	91,316	725,826	0.125810	237	30
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	2,861,314	48,383,537		1,565,895	79,808

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet D
Part IV
Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	357,947	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	357,947	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet D
Part IV
Date/Time Prepared:
12/20/2019 9:35 am

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	4,087,422	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	357,947	0	896,098	0.399451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,535,500	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,432,364	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,080,986	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,208,017	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	871,029	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,150,797	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,156,305	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	86,694	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,272,092	0.000000	73.00
76.00	03550	BEHAVORIAL HEALTH	0	0	0	278,730	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	0	1,912,838	0.000000	88.00
88.01	08801	RHC - GIRARD	0	0	0	264,477	0.000000	88.01
90.00	09000	CLINIC	0	0	0	401,089	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,023,273	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	725,826	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	357,947	0	48,383,537		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet D
Part IV
Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	24,062	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,311	2,521	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	327,699	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	350,276	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	118,836	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	63,654	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	26,153	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	20,351	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	166,900	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	443,253	0	0	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0.000000	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	5,328	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	12,835	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	237	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,565,895	2,521	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet D
Part V
Date/Time Prepared:
12/20/2019 9:35 am

			Title XVIII		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.433459	0	1,620,258	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.399451	0	393,941	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202640	0	4,781,848	0	0	54.00	
60.00	06000	LABORATORY	0.221201	0	3,676,486	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	1.009913	0	362,710	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.435173	0	1,916,423	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.466747	0	143,025	0	0	67.00	
69.00	06900	ELECTROCARDIOLOGY	0.435252	0	526,146	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.407518	0	270,098	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.702667	0	60,865	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.480676	0	1,341,289	2,908	0	73.00	
76.00	03550	BEHAVORIAL HEALTH	1.729821	0	278,364	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC - CARLINVILLE	0.000000				0	88.00	
88.01	08801	RHC - GIRARD	0.000000				0	88.01	
90.00	09000	CLINIC	2.059226	0	191,331	0	0	90.00	
91.00	09100	EMERGENCY	0.635331	0	1,762,022	329	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.734038	0	473,956	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00	
200.00		Subtotal (see instructions)		0	17,798,762	3,237	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	17,798,762	3,237	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet D
Part V
Date/Time Prepared:
12/20/2019 9:35 am

				Title XVIII	Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	702,315	0		50.00
53.00	05300	ANESTHESIOLOGY	157,360	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	968,994	0		54.00
60.00	06000	LABORATORY	813,242	0		60.00
65.00	06500	RESPIRATORY THERAPY	366,306	0		65.00
66.00	06600	PHYSICAL THERAPY	833,976	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	66,756	0		67.00
69.00	06900	ELECTROCARDIOLOGY	229,006	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,070	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,768	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644,725	1,398		73.00
76.00	03550	BEHAVORIAL HEALTH	481,520	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	0		88.00
88.01	08801	RHC - GIRARD	0	0		88.01
90.00	09000	CLINIC	393,994	0		90.00
91.00	09100	EMERGENCY	1,119,467	209		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	347,902	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,278,401	1,607		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,278,401	1,607		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:

Worksheet D

Component CCN: 14-Z347

From 08/01/2018
To 07/31/2019Part V
Date/Time Prepared:
12/20/2019 9:35 am

			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.433459	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.399451	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202640	0	0	0	0	54.00
60.00	06000	LABORATORY	0.221201	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.009913	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.435173	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466747	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.435252	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.407518	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.702667	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.480676	0	0	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	1.729821	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0.000000				0	88.00
88.01	08801	RHC - GIRARD	0.000000				0	88.01
90.00	09000	CLINIC	2.059226	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.635331	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.734038	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		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: 14-1347 Component CCN: 14-Z347		Period: From 08/01/2018 To 07/31/2019		Worksheet D Part V Date/Time Prepared: 12/20/2019 9:35 am		
				Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs							
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
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
69.00	06900	ELECTROCARDIOLOGY	0	0						69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0						73.00
76.00	03550	BEHAVORIAL HEALTH	0	0						76.00
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RHC - CARLINVILLE	0	0						88.00
88.01	08801	RHC - GIRARD	0	0						88.01
90.00	09000	CLINIC	0	0						90.00
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet D-1 Date/Time Prepared: 12/20/2019 9:35 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)		2,884	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,483	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)		1,054	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		584	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)		763	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		35	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)		19	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		695	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)		518	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)		610	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		160.07	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		164.87	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,523,363	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)		5,602	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)		3,133	25.00
26.00	Total swing-bed cost (see instructions)		1,681,601	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,841,762	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)		1,841,762	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,241.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		863,134	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)		863,134	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet D-1

Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description		Title XVIII		Hospital		Cost
		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)					625,993 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,489,127 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)					643,315 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					757,571 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,400,886 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)					429 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,241.92 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					532,784 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet D-1

Date/Time Prepared:
12/20/2019 9:35 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	603,882	3,523,363	0.171394	532,784	91,316
91.00	Nursing School cost	0	3,523,363	0.000000	532,784	0
92.00	Allied health cost	0	3,523,363	0.000000	532,784	0
93.00	All other Medical Education	0	3,523,363	0.000000	532,784	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet D-3 Date/Time Prepared: 12/20/2019 9:35 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		679,596		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.433459	24,062	10,430	50.00
53.00	05300 ANESTHESIOLOGY	0.399451	6,311	2,521	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.202640	327,699	66,405	54.00
60.00	06000 LABORATORY	0.221201	350,276	77,481	60.00
65.00	06500 RESPIRATORY THERAPY	1.009913	118,836	120,014	65.00
66.00	06600 PHYSICAL THERAPY	0.435173	63,654	27,701	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.466747	26,153	12,207	67.00
69.00	06900 ELECTROCARDIOLOGY	0.435252	20,351	8,858	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.407518	166,900	68,015	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.702667	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.480676	443,253	213,061	73.00
76.00	03550 BEHAVIORIAL HEALTH	1.729821	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - CARLINVILLE	0.000000		0	88.00
88.01	08801 RHC - GIRARD	0.000000		0	88.01
90.00	09000 CLINIC	2.059226	5,328	10,972	90.00
91.00	09100 EMERGENCY	0.635331	12,835	8,154	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.734038	237	174	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,565,895	625,993	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,565,895		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1347 Component CCN: 14-Z347	Period: From 08/01/2018 To 07/31/2019	Worksheet D-3 Date/Time Prepared: 12/20/2019 9:35 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.433459	5,668	2,457	50.00
53.00	05300 ANESTHESIOLOGY	0.399451	1,229	491	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.202640	86,169	17,461	54.00
60.00	06000 LABORATORY	0.221201	270,237	59,777	60.00
65.00	06500 RESPIRATORY THERAPY	1.009913	73,225	73,951	65.00
66.00	06600 PHYSICAL THERAPY	0.435173	329,995	143,605	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.466747	253,304	118,229	67.00
69.00	06900 ELECTROCARDIOLOGY	0.435252	4,455	1,939	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.407518	153,957	62,740	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.702667	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.480676	397,178	190,914	73.00
76.00	03550 BEHAVIORIAL HEALTH	1.729821	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - CARLINVILLE	0.000000		0	88.00
88.01	08801 RHC - GIRARD	0.000000		0	88.01
90.00	09000 CLINIC	2.059226	5,368	11,054	90.00
91.00	09100 EMERGENCY	0.635331	8,701	5,528	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.734038	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,589,486	688,146	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,589,486		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet E Part B Date/Time Prepared: 12/20/2019 9:35 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,280,008	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
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 lines 3, 4, and 4.01, 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)		7,280,008	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 (see instructions)		7,352,808	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, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		60,341	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,819,392	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)		4,473,075	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)		4,473,075	30.00
31.00	Primary payer payments		1,773	31.00
32.00	Subtotal (line 30 minus line 31)		4,471,302	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)		418,251	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		271,863	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		406,629	36.00
37.00	Subtotal (see instructions)		4,743,165	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
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
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)		4,743,165	40.00
40.01	Sequestration adjustment (see instructions)		94,863	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,504,821	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		143,481	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: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet E-1
Part I
Date/Time Prepared:
12/20/2019 9:35 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		1,113,416		4,088,657	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	07/15/2019	45,804	07/15/2019	203,211	3.01
3.02		07/15/2019	204,993	07/15/2019	212,953	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)		250,797		416,164	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)		1,364,213		4,504,821	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		143,481	6.01
6.02	SETTLEMENT TO PROGRAM		75,790		0	6.02
7.00	Total Medicare program liability (see instructions)		1,288,423		4,648,302	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: 14-1347

Period:

Worksheet E-1

Component CCN: 14-Z347

From 08/01/2018
To 07/31/2019Part I
Date/Time Prepared:
12/20/2019 9:35 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		1,843,599		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		07/15/2019	155,479		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)		155,479		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)		1,999,078		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		50,638		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,049,716		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: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet E-1
Part II
Date/Time Prepared:
12/20/2019 9:35 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			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1347

Period:

Worksheet E-2

Component CCN: 14-Z347

From 08/01/2018

Date/Time Prepared:

To 07/31/2019

12/20/2019 9:35 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)		1,414,895	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)		695,027	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,128	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)		2,109,922	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,109,922	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)		2,109,922	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		18,375	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)		2,091,547	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
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)		2,091,547	0	19.00
19.01	Sequestration adjustment (see instructions)		41,831	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,999,078	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)		50,638	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
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet E-3 Part V Date/Time Prepared: 12/20/2019 9:35 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,489,127	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)		1,489,127	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,504,018	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)		1,504,018	19.00
20.00	Deductibles (exclude professional component)		221,872	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,282,146	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,282,146	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		50,109	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		32,571	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		47,453	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,314,717	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	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,314,717	30.00
30.01	Sequestration adjustment (see instructions)		26,294	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,364,213	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, 30.02, 31, and 32)		-75,790	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet G

Date/Time Prepared:
12/20/2019 9:35 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	1,971,523	0	0	0	1.00
2.00	Temporary investments	1,141,113	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,372,678	0	0	0	4.00
5.00	Other receivable	1,386,264	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-658,000	0	0	0	6.00
7.00	Inventory	232,949	0	0	0	7.00
8.00	Prepaid expenses	247,539	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,694,066	0	0	0	11.00
FIXED ASSETS						
12.00	Land	500,172	0	0	0	12.00
13.00	Land improvements	2,432,796	0	0	0	13.00
14.00	Accumulated depreciation	-956,979	0	0	0	14.00
15.00	Buildings	28,205,020	0	0	0	15.00
16.00	Accumulated depreciation	-11,550,729	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,521,481	0	0	0	23.00
24.00	Accumulated depreciation	-5,770,225	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	1,180,327	0	0	0	27.00
28.00	Accumulated depreciation	-935,867	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)	20,625,996	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	5,811,436	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,811,436	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,131,498	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,122,677	0	0	0	37.00
38.00	Salaries, wages, and fees payable	851,031	0	0	0	38.00
39.00	Payroll taxes payable	30,796	0	0	0	39.00
40.00	Notes and loans payable (short term)	975,204	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	164,433	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,144,141	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	14,703,667	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)	14,703,667	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,847,808	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	17,283,690				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	17,283,690	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,131,498	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet G-1

Date/Time Prepared:
12/20/2019 9:35 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		16,740,050		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		559,163				2.00
3.00	Total (sum of line 1 and line 2)		17,299,213		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,299,213		0		11.00
12.00	DECREASE IN PERM RESTRICTED	15,523		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)		15,523		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,283,690		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	DECREASE IN PERM RESTRICTED		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: 14-1347

Period:
From 08/01/2018
To 07/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
12/20/2019 9:35 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,778,807		1,778,807	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	715,282		715,282	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	2,494,089		2,494,089	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,494,089		2,494,089	17.00
18.00	Ancillary services	4,462,101		4,462,101	18.00
19.00	Outpatient services	0	44,432,086	44,432,086	19.00
20.00	RHC - CARLINVILLE	0	1,912,838	1,912,838	20.00
20.01	RHC - GIRARD	0	565,362	565,362	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	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,956,190	46,910,286	53,866,476	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,352,938		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	MISC	4,690			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		4,690		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,348,248		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2018
To 07/31/2019

Worksheet G-3

Date/Time Prepared:
12/20/2019 9:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,866,476	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,129,297	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,737,179	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,348,248	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,611,069	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	66,102	6.00
7.00	Income from investments	216,871	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	26,412	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	75,784	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	242,817	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	18,916	24.01
24.02	PHYSICAL THERAPY - NON PATIENTS	0	24.02
24.03	OTHER	76,290	24.03
24.04	340B REVENUE	399,817	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	1,026,927	24.05
24.06	GRANTS	20,296	24.06
25.00	Total other income (sum of lines 6-24)	2,170,232	25.00
26.00	Total (line 5 plus line 25)	559,163	26.00
27.00	LOSS FROM DISPOSAL	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	559,163	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8530

From 08/01/2018

To 07/31/2019

Date/Time Prepared:

12/20/2019 9:35 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	487,186	0	487,186	0	487,186
2.00	Physician Assistant	67,359	0	67,359	0	67,359
3.00	Nurse Practitioner	57,146	0	57,146	0	57,146
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	1,014,778	260,141	1,274,919	-165,277	1,109,642
10.00	Subtotal (sum of lines 1 through 9)	1,626,469	260,141	1,886,610	-165,277	1,721,333
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,626,469	260,141	1,886,610	-165,277	1,721,333
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	0	0	0	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,626,469	260,141	1,886,610	-165,277	1,721,333

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8530

From 08/01/2018
To 07/31/2019Date/Time Prepared:
12/20/2019 9:35 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	487,186	1.00
2.00	Physician Assistant	0	67,359	2.00
3.00	Nurse Practitioner	0	57,146	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	1,109,642	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,721,333	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,721,333	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,721,333	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8532

From 08/01/2018
To 07/31/2019Date/Time Prepared:
12/20/2019 9:35 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	48,736	0	48,736	0	48,736
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	98,364	0	98,364	0	98,364
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	116,241	56,883	173,124	-35,674	137,450
10.00	Subtotal (sum of lines 1 through 9)	263,341	56,883	320,224	-35,674	284,550
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	263,341	56,883	320,224	-35,674	284,550
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	0	0	0	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0
32.00	Total facility costs (sum of lines 22, 28 and 31)	263,341	56,883	320,224	-35,674	284,550

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8532

From 08/01/2018
To 07/31/2019Date/Time Prepared:
12/20/2019 9:35 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	48,736		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	98,364		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	137,450		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	284,550		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	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	284,550		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	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	284,550		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347

Period:

Worksheet M-2

Component CCN: 14-8530

From 08/01/2018
To 07/31/2019Date/Time Prepared:
12/20/2019 9:35 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	2.86	10,041	4,200	12,012		1.00
2.00	Physician Assistant	0.58	828	2,100	1,218		2.00
3.00	Nurse Practitioner	0.55	1,172	2,100	1,155		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.99	12,041		14,385	14,385	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)	3.99	12,041			14,385	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)					1,721,333	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)					1,721,333	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)					1,351,938	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,351,938	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,351,938	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,351,938	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,073,271	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1347 Component CCN: 14-8532		Period: From 08/01/2018 To 07/31/2019		Worksheet M-2 Date/Time Prepared: 12/20/2019 9:35 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	0.18	326	4,200	756			1.00
2.00	Physician Assistant	0.00	6	2,100	0			2.00
3.00	Nurse Practitioner	0.79	1,632	2,100	1,659			3.00
4.00	Subtotal (sum of lines 1 through 3)	0.97	1,964		2,415		2,415	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)	0.97	1,964				2,415	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)						284,550	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)						284,550	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)						174,025	15.00
16.00	Total overhead (sum of lines 14 and 15)						174,025	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						174,025	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						174,025	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						458,575	20.00

Health Financial Systems		CARLINVILLE AREA HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1347	Period: From 08/01/2018 To 07/31/2019	Worksheet M-3	
		Component CCN: 14-8530		Date/Time Prepared: 12/20/2019 9:35 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)			3,073,271	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			17,104	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,056,167	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,385	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)			14,385	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			212.46	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		212.46	212.46	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,349	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	499,069	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	499,069	16.00
16.01	Total program charges (see instructions)(from contractor's records)			286,519	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			16,508	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			28,754	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.)			354,210	16.04
16.05	Total program cost (see instructions)		0	382,964	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			27,553	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			48,492	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			382,964	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			17,104	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			400,068	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			400,068	26.00
26.01	Sequestration adjustment (see instructions)			8,001	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			450,481	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, 26.02, 27, and 28)			-58,414	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: 14-1347 Component CCN: 14-8532	Period: From 08/01/2018 To 07/31/2019	Worksheet M-3 Date/Time Prepared: 12/20/2019 9:35 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)			458,575	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			3,694	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			454,881	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,415	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)			2,415	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			188.36	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			188.36	188.36	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	449	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	84,574	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	84,574	16.00
16.01	Total program charges (see instructions)(from contractor's records)				55,513	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				4,730	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				7,206	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.)				57,278	16.04
16.05	Total program cost (see instructions)			0	64,484	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				5,770	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				9,003	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				64,484	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				3,694	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				68,178	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				68,178	26.00
26.01	Sequestration adjustment (see instructions)				1,364	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				60,703	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, 26.02, 27, and 28)				6,111	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2018 To 07/31/2019	Worksheet M-4 Date/Time Prepared: 12/20/2019 9:35 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,721,333	1,721,333	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000075	0.000258	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		129	444	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,843	3,164	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		5,972	3,608	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,721,333	1,721,333	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,351,938	1,351,938	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003469	0.002096	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,690	2,834	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		10,662	6,442	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		32	111	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		333.19	58.04	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		32	111	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		10,662	6,442	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			17,104	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			17,104	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1347 Component CCN: 14-8532	Period: From 08/01/2018 To 07/31/2019	Worksheet M-4 Date/Time Prepared: 12/20/2019 9:35 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		284,550	284,550	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000140	0.000230	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		40	65	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,826	361	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,866	426	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		284,550	284,550	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		174,025	174,025	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.006558	0.001497	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,141	261	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		3,007	687	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		10	16	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		300.70	42.94	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		10	16	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		3,007	687	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			3,694	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			3,694	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2018 To 07/31/2019	Worksheet M-5 Date/Time Prepared: 12/20/2019 9:35 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		373,284	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		07/15/2019	77,197	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)		77,197	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		450,481	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		58,414	6.02	
7.00	Total Medicare program liability (see instructions)		392,067	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: 14-1347 Component CCN: 14-8532	Period: From 08/01/2018 To 07/31/2019	Worksheet M-5 Date/Time Prepared: 12/20/2019 9:35 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			53,704	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			07/15/2019	6,999	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)			6,999	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			60,703	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			6,111	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			66,814	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00