

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 08/01/2019
To 07/31/2020

Worksheet S
Parts I-III
Date/Time Prepared:
12/22/2020 8:49 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 12/22/2020	Time: 8:49 am
	2. ☐ Manually prepared 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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 08/01/2019 and ending 07/31/2020 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.

Encryption Information

ECR: Date: 12/22/2020 Time: 8:49 am

OPxp9p3ie3p9JfBjEHEZAHXJafg7L0

eUr040v5xbNi7znCCVgGL.dpc20Ppw

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PI: Date: 12/22/2020 Time: 8:49 am

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4sM:D0aZ4NjQv0mKI:asNt1xj30Y7g

w:FI0kqAVj0CURSL

(Signed)

Richard Schen

Officer or Administrator of Provider(s)

Board Chairman

Title

Dec 23, 2020

Date

		Title XVIII		HIT	Title XIX	
Title V		Part A	Part B			
1.00		2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-26,527	188,740	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	107,193	0	0	5.00
6.00	Swing Bed - NF	0	0	0	0	6.00
10.00	RHC - CARLINVILLE I	0	0	100,744	0	10.00
10.01	RHC - GIRARD II	0	0	20,697	0	10.01
200.00	Total	0	80,666	310,181	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 08/01/2019 To 07/31/2020		Worksheet S-2 Part I Date/Time Prepared: 12/22/2020 8:49 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	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		CARLINVILLE AREA HOSPITAL	141347	41180	1	07/01/2005	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		CARLINVILLE AREA HOSPITAL SWING BED	142347	99914		07/01/2005	N	O	N
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	N
15.01	Hospital-Based Health Clinic - RHC II		GIRARD RHC	148532	99914		02/12/2014	N	O	N
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)						08/01/2019	07/31/2020		20.00
21.00	Type of Control (see instructions)						2			21.00
							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			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347		Period: From 08/01/2019 To 07/31/2020		Worksheet S-2 Part I Date/Time Prepared: 12/22/2020 8:49 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		Date of Geogr				
		1.00		2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00		
		Beginning:		Ending:				
		1.00		2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	0				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00		
		Y/N		Y/N				
		1.00		2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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		XVIII		XIX		
		1.00		2.00		3.00		
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N		N		45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N		46.00		
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		47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00		
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N				56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00		

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		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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						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			
64.00	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. 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

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet S-2
Part I
Date/Time Prepared:
12/22/2020 8:49 am

		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
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00
							1.00 2.00 3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N					70.00
71.00	If line 70 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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347	Period: From 08/01/2019 To 07/31/2020	Worksheet S-2 Part I Date/Time Prepared: 12/22/2020 8:49 am
		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
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
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		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:	221,894	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	Removed and reserved			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 08/01/2019 To 07/31/2020	Worksheet S-2 Part I Date/Time Prepared: 12/22/2020 8:49 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:		
142.00	Street:	PO Box:				
143.00	City:	State:		Zip Code:		
				1.00		
144.00 Are provider based physicians' costs included in worksheet A?				Y	144.00	
				1.00	2.00	
145.00	If costs for renal services are claimed on wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146.00	
				1.00		
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 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	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
				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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00
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)				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 1.00	Ending 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)				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	0171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1347		Period: From 08/01/2019 To 07/31/2020		Worksheet S-2 Part II Date/Time Prepared: 12/22/2020 8:49 am	
		Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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	03/31/2021			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 1.00	Legal Oper. 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 1.00	Date 2.00	Y/N 3.00	Date 4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/01/2020	Y	12/01/2020		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet S-2
Part II
Date/Time Prepared:
12/22/2020 8:49 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.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		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.	PATRICK		NUDO	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		PNUDO@CAHCARE.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1347	Period: From 08/01/2019 To 07/31/2020	Worksheet S-2 Part II Date/Time Prepared: 12/22/2020 8:49 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 08/01/2019
To 07/31/2020Worksheet S-3
Part I
Date/Time Prepared:
12/22/2020 8:49 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	9,150	20,184.00	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	9,150	20,184.00	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	9,150	20,184.00	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 08/01/2019
To 07/31/2020Worksheet S-3
Part I
Date/Time Prepared:
12/22/2020 8:49 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)	521	73	841			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,239	0	1,385			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	34			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,760	73	2,260			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)	1,760	73	2,260	0.00	157.90	14.00
15.00 CAH visits	12,675	3,524	23,569			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	2,257	3,263	11,799	0.00	20.39	26.00
26.01 RHC - GIRARD	276	533	1,464	0.00	2.53	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	180.82	27.00
28.00 Observation Bed Days		81	384			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 08/01/2019
To 07/31/2020Worksheet S-3
Part I
Date/Time Prepared:
12/22/2020 8:49 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		
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	179	26	282	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	179	26	282	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1347

Period:

Worksheet S-8

Component CCN: 14-8530

From 08/01/2019

To 07/31/2020

Date/Time Prepared:
12/22/2020 8:49 am

		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	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
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0
				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
				1.00	2.00
				Sunday	Monday
				from	to
				1.00	2.00
				from	to
				3.00	4.00
				from	to
				5.00	
	Facility hours of operations (1)				
11.00	CLINIC			07:30	16:00
				07:30	
				1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?			Y	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
				1.00	2.00
				Provider name	CCN number
				1.00	2.00
14.00	RHC/FQHC name, CCN number				
				Y/N	V
				1.00	2.00
				XVIII	XIX
				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)				
				County	
				4.00	
2.00	City, State, ZIP Code, County			MACOUPIN	
				Tuesday	wednesday
				to	to
				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	16:00
				11.00	

Health Financial Systems		CARLINVILLE AREA HOSPITAL				In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1347		Period: From 08/01/2019	Worksheet S-8
				Component CCN: 14-8530		To 07/31/2020	Date/Time Prepared: 12/22/2020 8:49 am
						RHC I	Cost
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	07:30	16:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1347

Period:

Worksheet S-8

Component CCN: 14-8532

From 08/01/2019
To 07/31/2020Date/Time Prepared:
12/22/2020 8:49 am

RHC II

Cost

		1.00			
1.00	Clinic Address and Identification				
	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	11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		Y		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
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		11.00	

Health Financial Systems		CARLINVILLE AREA HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1347	Period: From 08/01/2019	Worksheet S-8	
		Component CCN: 14-8532	To 07/31/2020	Date/Time Prepared: 12/22/2020 8:49 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 08/01/2019 To 07/31/2020	Worksheet S-10 Date/Time Prepared: 12/22/2020 8:49 am
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				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)			0.531775	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2,173,232	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			1,953,149	5.00
6.00	Medicaid charges			8,662,308	6.00
7.00	Medicaid cost (line 1 times line 6)			4,606,399	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)			480,018	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			23,366	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			480,018	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)	216,342	0	216,342	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	115,045	0	115,045	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)	115,045	0	115,045	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)			978,451	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			220,611	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			339,401	27.01
28.00	Non-Medicare bad debt expense (see instructions)			639,050	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			458,621	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			573,666	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,053,684	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet A

Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		2,566,162	2,566,162	-117,524	2,448,638	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	849,909	849,909	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	109,589	2,806,314	2,915,903	0	2,915,903	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1,512,605	2,933,909	4,446,514	138,011	4,584,525	5.00
7.00	00700 OPERATION OF PLANT	317,854	461,274	779,128	0	779,128	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	307,098	307,098	0	307,098	8.00
9.00	00900 HOUSEKEEPING	314,256	42,492	356,748	0	356,748	9.00
10.00	01000 DIETARY	203,545	234,355	437,900	0	437,900	10.00
11.00	01100 CAFETERIA	0	0	0	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	334,732	15,507	350,239	0	350,239	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	95,304	184,370	279,674	0	279,674	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	224,264	60,692	284,956	0	284,956	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	247,992	8,048	256,040	0	256,040	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	971,459	254,295	1,225,754	0	1,225,754	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	360,154	762,725	1,122,879	0	1,122,879	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	562,620	872,174	1,434,794	651	1,435,445	54.00
60.00	06000 LABORATORY	696,302	753,475	1,449,777	0	1,449,777	60.00
65.00	06500 RESPIRATORY THERAPY	470,474	54,872	525,346	0	525,346	65.00
66.00	06600 PHYSICAL THERAPY	928,659	52,750	981,409	0	981,409	66.00
67.00	06700 OCCUPATIONAL THERAPY	234,872	6,508	241,380	0	241,380	67.00
69.00	06900 ELECTROCARDIOLOGY	105,664	73,683	179,347	0	179,347	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	44,461	44,461	0	44,461	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	238,231	1,084,544	1,322,775	0	1,322,775	73.00
76.00	03550 BEHAVIORAL HEALTH	111,969	95,207	207,176	0	207,176	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	1,814,670	258,808	2,073,478	-189,943	1,883,535	88.00
88.01	08801 RHC - GIRARD	234,201	51,392	285,593	-38,097	247,496	88.01
90.00	09000 CLINIC	269,703	111,006	380,709	0	380,709	90.00
91.00	09100 EMERGENCY	1,288,824	1,863,824	3,152,648	0	3,152,648	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		643,007	643,007	-643,007	0	113.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	11,647,943	16,602,952	28,250,895	0	28,250,895	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	58,335	58,335	0	58,335	194.00
194.01	07951 FUND DEVELOPMENT	14,380	19	14,399	0	14,399	194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	11,662,323	16,661,306	28,323,629	0	28,323,629	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet A

Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-202,970	2,245,668	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-1,550	848,359	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2,915,903	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-356,684	4,227,841	5.00
7.00	00700 OPERATION OF PLANT	0	779,128	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	307,098	8.00
9.00	00900 HOUSEKEEPING	0	356,748	9.00
10.00	01000 DIETARY	-83,380	354,520	10.00
11.00	01100 CAFETERIA	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	350,239	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	279,674	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-7,026	277,930	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	-176,169	79,871	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1,225,754	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-347,185	775,694	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-187,452	1,247,993	54.00
60.00	06000 LABORATORY	-150	1,449,627	60.00
65.00	06500 RESPIRATORY THERAPY	0	525,346	65.00
66.00	06600 PHYSICAL THERAPY	-3,963	977,446	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	241,380	67.00
69.00	06900 ELECTROCARDIOLOGY	-39,920	139,427	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	44,461	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-228,699	1,094,076	73.00
76.00	03550 BEHAVIORAL HEALTH	0	207,176	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC - CARLINVILLE	0	1,883,535	88.00
88.01	08801 RHC - GIRARD	0	247,496	88.01
90.00	09000 CLINIC	-35,227	345,482	90.00
91.00	09100 EMERGENCY	-990,364	2,162,284	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)	-2,660,739	25,590,156	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950 NONREIMBURSABLE COSTS CENTERS	0	58,335	194.00
194.01	07951 FUND DEVELOPMENT	0	14,399	194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	-2,660,739	25,662,890	200.00

		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	12,138	1.00
	TOTALS			0	12,138	
B - TO RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-MVBLE	2.00		0	825,063	1.00
	EQUIP					
	TOTALS			0	825,063	
C - INSURANCE EXPENSE						
1.00	OTHER CAPITAL RELATED COSTS	3.00		0	90,029	1.00
	TOTALS			0	90,029	
E - INTEREST EXPENSE RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00		0	651	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00		0	642,356	2.00
	TOTALS			0	643,007	
L - RECLASS RHC ADMIN SALARIES TO ADMIN						
1.00	ADMINISTRATIVE & GENERAL	5.00		240,178	0	1.00
2.00		0.00		0	0	2.00
	TOTALS			240,178	0	
500.00	Grand Total: Increases			240,178	1,570,237	500.00

		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	12,138	0	1.00
	TOTALS			0	12,138		
B - TO RECLASS DEPRECIATION EXPENSE							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00		0	825,063	9	1.00
	TOTALS			0	825,063		
C - INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00		0	90,029	0	1.00
	TOTALS			0	90,029		
E - INTEREST EXPENSE RECLASS							
1.00	INTEREST EXPENSE	113.00		0	643,007	9	1.00
2.00		0.00		0	0	9	2.00
	TOTALS			0	643,007		
L - RECLASS RHC ADMIN SALARIES TO ADMIN							
1.00	RHC - CARLINVILLE	88.00		202,081	0	0	1.00
2.00	RHC - GIRARD	88.01		38,097	0	0	2.00
	TOTALS			240,178	0		
500.00	Grand Total: Decreases			240,178	1,570,237		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet A-7
Part I
Date/Time Prepared:
12/22/2020 8:49 am

		Beginning Balances 1.00	Acquisitions			Disposals and Retirements 5.00	
			Purchases 2.00	Donation 3.00	Total 4.00		
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	77,293	0	77,293	0	2.00
3.00	Buildings and Fixtures	28,205,019	285,454	0	285,454	2,337,542	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	7,521,481	2,414,668	0	2,414,668	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)	39,839,795	2,777,415	0	2,777,415	2,337,542	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,839,795	2,777,415	0	2,777,415	2,337,542	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	2,510,089	0				2.00
3.00	Buildings and Fixtures	26,152,931	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9,936,149	0				6.00
7.00	HIT designated Assets	1,180,327	0				7.00
8.00	Subtotal (sum of lines 1-7)	40,279,668	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	40,279,668	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet A-7
Part II
Date/Time Prepared:
12/22/2020 8:49 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	2,566,162	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,566,162	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,566,162				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,566,162				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet A-7
Part III
Date/Time Prepared:
12/22/2020 8:49 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	29,163,192	0	29,163,192	0.724018	65,183	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	11,116,476	0	11,116,476	0.275982	24,846	2.00
3.00	Total (sum of lines 1-2)	40,279,668	0	40,279,668	1.000000	90,029	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	65,183	2,180,485	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	24,846	823,513	0	2.00
3.00	Total (sum of lines 1-2)	0	0	90,029	3,003,998	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	65,183	0	0	2,245,668	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	24,846	0	0	848,359	2.00
3.00	Total (sum of lines 1-2)	0	90,029	0	0	3,094,027	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet A-8

Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	wkst. A-7	Ref.
				Cost Center				
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	-35,386	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	-591	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	-2,759	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	-1,330,504					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	-83,380	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	-33,062	DRUGS CHARGED TO PATIENTS		73.00		0 17.00
18.00	Sale of medical records and abstracts	B	-7,026	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

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet A-8
Date/Time Prepared:
12/22/2020 8:49 am

			Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	wkst. A-7 Ref.		
	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	0	DIETARY	10.00		0	33.00
33.01 RADIOLOGY DISCOUNTS	B	-19,570	RADIOLOGY-DIAGNOSTIC	54.00		0	33.01
33.02 PT PROF FEES	B	-225	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	-7,045	OPERATING ROOM	50.00		0	33.05
33.06 AHA & IHA DUES	A	-16,354	ADMINISTRATIVE & GENERAL	5.00		0	33.06
33.07 PLANT OPERATION DISCOUNTS	B	0	OPERATION OF PLANT	7.00		0	33.07
36.00 ACQUATIC THERAPY	B	-3,738	PHYSICAL THERAPY	66.00		0	36.00
37.00 INSURANCE PROCEEDS	B	-167,651	RADIOLOGY-DIAGNOSTIC	54.00		0	37.00
39.00 MED STAFF RELATIONS	A	-3,373	ADMINISTRATIVE & GENERAL	5.00		0	39.00
40.00 SPECIAL EVENTS - OUTREACH	A	-15,751	ADMINISTRATIVE & GENERAL	5.00		0	40.00
41.00 PROMOTIONAL ITEMS - OUTREACH	A	-8,766	ADMINISTRATIVE & GENERAL	5.00		0	41.00
42.00 ADVERTISING	A	-243,489	ADMINISTRATIVE & GENERAL	5.00		0	42.00
44.00 TELEPHONE DEPRECIATION	A	-1,707	NEW CAP REL COSTS-BLDG & FIXT	1.00		9	44.00
44.01 TELEPHONE TRUNKLINE CHARGES	A	-1,782	ADMINISTRATIVE & GENERAL	5.00		0	44.01
44.02 SPRINGFIELD CLINIC RENT	B	-35,227	CLINIC	90.00		0	44.02
44.03 PATIENT TELEVISION OFFSET	A	-2,773	ADMINISTRATIVE & GENERAL	5.00		0	44.03
44.04 INSURANCE PROCEEDS	A	0	ADMINISTRATIVE & GENERAL	5.00		0	44.04
44.05 MOB BUILDING RENT	B	-208,996	NEW CAP REL COSTS-BLDG & FIXT	1.00		9	44.05
44.06 PHARMACY DISCOUNTS	B	-7	DRUGS CHARGED TO PATIENTS	73.00		0	44.06
44.07 SALE OF LABS	B	-150	LABORATORY	60.00		0	44.07
45.00 SALE OF X-RAYS	B	-231	RADIOLOGY-DIAGNOSTIC	54.00		0	45.00
45.01 340B PROGRAM	B	-195,630	DRUGS CHARGED TO PATIENTS	73.00		0	45.01
45.02 RHC TECHNOLOGY UPGRADE SETTLEMENT	B	-40,000	ADMINISTRATIVE & GENERAL	5.00		0	45.02
45.03 CRNA COSTS	A	-150,123	NONPHYSICIAN ANESTHETISTS	19.00		0	45.03
45.04 CRNA BENEFITS	A	-26,046	NONPHYSICIAN ANESTHETISTS	19.00		0	45.04
45.05 EKG PROFESSIONAL FEES	A	-39,920	ELECTROCARDIOLOGY	69.00		0	45.05
45.06 PROFESSIONAL BILLING COSTS	A	-21,046	ADMINISTRATIVE & GENERAL	5.00		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.)		-2,660,739					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 08/01/2019
To 07/31/2020

Worksheet A-8-2

Date/Time Prepared:
12/22/2020 8:49 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	525,810	1,174,190	0	0	1.00
2.00	91.00	EMERGENCY	396,686	396,686	0	0	0	2.00
3.00	50.00	OPERATING ROOM	340,140	340,140	0	0	0	3.00
4.00	91.00	EMERGENCY	67,868	67,868	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			2,504,694	1,330,504	1,174,190	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	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	525,810		1.00
2.00	91.00	EMERGENCY	0	0	0	396,686		2.00
3.00	50.00	OPERATING ROOM	0	0	0	340,140		3.00
4.00	91.00	EMERGENCY	0	0	0	67,868		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	1,330,504		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet B
Part I
Date/Time Prepared:
12/22/2020 8:49 am

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	2,245,668	2,245,668			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	848,359	848,359			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,915,903	4,083	4,305	2,924,291	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,227,841	478,496	188,289	443,677	5,338,303
7.00	00700	OPERATION OF PLANT	779,128	258,756	22,638	80,457	1,140,979
8.00	00800	LAUNDRY & LINEN SERVICE	307,098	0	0	0	307,098
9.00	00900	HOUSEKEEPING	356,748	10,576	18	79,546	446,888
10.00	01000	DIETARY	354,520	40,716	17,131	51,522	463,889
11.00	01100	CAFETERIA	0	41,028	0	0	41,028
13.00	01300	NURSING ADMINISTRATION	350,239	6,720	639	84,729	442,327
14.00	01400	CENTRAL SERVICE & SUPPLY	279,674	23,448	1,016	24,124	328,262
16.00	01600	MEDICAL RECORDS & LIBRARY	277,930	30,310	2,949	56,767	367,956
19.00	01900	NONPHYSICIAN ANESTHETISTS	79,871	2,240	13,088	62,773	157,972
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,225,754	317,788	102,843	245,901	1,892,286
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	775,694	149,140	43,859	91,164	1,059,857
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,247,993	100,145	335,657	142,413	1,826,208
60.00	06000	LABORATORY	1,449,627	41,765	24,369	176,251	1,692,012
65.00	06500	RESPIRATORY THERAPY	525,346	90,618	22,104	119,089	757,157
66.00	06600	PHYSICAL THERAPY	977,446	185,064	22,688	235,067	1,420,265
67.00	06700	OCCUPATIONAL THERAPY	241,380	14,035	0	59,452	314,867
69.00	06900	ELECTROCARDIOLOGY	139,427	85,827	17,200	26,746	269,200
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,461	0	0	0	44,461
73.00	07300	DRUGS CHARGED TO PATIENTS	1,094,076	18,260	10,847	60,302	1,183,485
76.00	03550	BEHAVIORAL HEALTH	207,176	37,370	961	28,342	273,849
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	1,883,535	167,372	4,643	408,187	2,463,737
88.01	08801	RHC - GIRARD	247,496	0	0	49,639	297,135
90.00	09000	CLINIC	345,482	72,387	1,918	68,269	488,056
91.00	09100	EMERGENCY	2,162,284	62,605	10,877	326,234	2,562,000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,590,156	2,238,749	848,039	2,920,651	25,579,277
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,189	19	0	5,208
194.00	07950	NONREIMBURSABLE COSTS CENTERS	58,335	0	0	0	58,335
194.01	07951	FUND DEVELOPMENT	14,399	1,730	301	3,640	20,070
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	25,662,890	2,245,668	848,359	2,924,291	25,662,890

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet B
Part I
Date/Time Prepared:
12/22/2020 8:49 am

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	5,338,303				5.00
7.00	00700	OPERATION OF PLANT	299,680	1,440,659			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	80,660	0	387,758		8.00
9.00	00900	HOUSEKEEPING	117,376	10,128	0	574,392	9.00
10.00	01000	DIETARY	121,841	38,993	0	14,883	10.00
11.00	01100	CAFETERIA	10,776	39,291	0	14,997	11.00
13.00	01300	NURSING ADMINISTRATION	116,178	6,435	0	2,456	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	86,219	22,456	0	8,571	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96,644	29,027	0	11,079	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	41,492	2,145	0	819	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	497,013	304,339	182,418	116,162	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	278,374	142,828	32,235	54,515	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	479,657	95,906	35,618	36,606	54.00
60.00	06000	LABORATORY	444,410	39,997	0	15,266	60.00
65.00	06500	RESPIRATORY THERAPY	198,869	86,783	2,711	33,124	65.00
66.00	06600	PHYSICAL THERAPY	373,035	177,231	31,760	67,647	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,700	13,441	0	5,130	67.00
69.00	06900	ELECTROCARDIOLOGY	70,706	82,194	0	31,372	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,678	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,845	17,487	0	6,675	73.00
76.00	03550	BEHAVIORIAL HEALTH	71,927	35,788	0	13,660	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	647,105	160,287	220	61,180	88.00
88.01	08801	RHC - GIRARD	78,043	0	0	28,377	88.01
90.00	09000	CLINIC	128,189	69,323	0	26,460	90.00
91.00	09100	EMERGENCY	672,925	59,955	102,796	22,884	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)	5,316,342	1,434,034	387,758	571,863	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,368	4,969	0	1,897	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	15,322	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	5,271	1,656	0	632	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,338,303	1,440,659	387,758	574,392	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	14.00	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	536,689					11.00
13.00	01300 NURSING ADMINISTRATION	14,750	582,146				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	8,976	0	454,484			14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	27,705	0	0	532,411		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	5,046	12,151	0	0	219,625	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	103,497	249,041	0	27,611	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	26,007	62,584	0	35,602	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	4,149	219,625	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	46,531	0	0	144,883	0	54.00
60.00	06000 LABORATORY	61,476	0	0	105,811	0	60.00
65.00	06500 RESPIRATORY THERAPY	36,536	0	0	9,682	0	65.00
66.00	06600 PHYSICAL THERAPY	63,174	0	0	49,615	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	13,246	0	0	10,783	0	67.00
69.00	06900 ELECTROCARDIOLOGY	9,413	0	0	11,080	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	454,484	11,795	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	854	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,411	34,719	0	37,434	0	73.00
76.00	03550 BEHAVIORAL HEALTH	9,656	23,230	0	2,515	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	0	0	0	21,929	0	88.00
88.01	08801 RHC - GIRARD	0	0	0	2,580	0	88.01
90.00	09000 CLINIC	23,290	56,046	0	2,858	0	90.00
91.00	09100 EMERGENCY	68,123	144,375	0	53,230	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		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	531,837	582,146	454,484	532,411	219,625	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	0	0	0	0	194.00
194.01	07951 FUND DEVELOPMENT	4,852	0	0	0	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)	536,689	582,146	454,484	532,411	219,625	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	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
14.00	01400 CENTRAL SERVICE & SUPPLY				14.00
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	3,581,376	0	3,581,376	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1,692,002	0	1,692,002	50.00
53.00	05300 ANESTHESIOLOGY	223,774	0	223,774	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,665,409	0	2,665,409	54.00
60.00	06000 LABORATORY	2,358,972	0	2,358,972	60.00
65.00	06500 RESPIRATORY THERAPY	1,124,862	0	1,124,862	65.00
66.00	06600 PHYSICAL THERAPY	2,182,727	0	2,182,727	66.00
67.00	06700 OCCUPATIONAL THERAPY	440,167	0	440,167	67.00
69.00	06900 ELECTROCARDIOLOGY	473,965	0	473,965	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	466,279	0	466,279	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	56,993	0	56,993	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,605,056	0	1,605,056	73.00
76.00	03550 BEHAVIORIAL HEALTH	430,625	0	430,625	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - CARLINVILLE	3,354,458	0	3,354,458	88.00
88.01	08801 RHC - GIRARD	406,135	0	406,135	88.01
90.00	09000 CLINIC	794,222	0	794,222	90.00
91.00	09100 EMERGENCY	3,686,288	0	3,686,288	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		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	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	25,543,310	0	25,543,310	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	13,442	0	13,442	190.00
194.00	07950 NONREIMBURSABLE COSTS CENTERS	73,657	0	73,657	194.00
194.01	07951 FUND DEVELOPMENT	32,481	0	32,481	194.01
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	25,662,890	0	25,662,890	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Directly Assigned New Capital Related Costs	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	4,083	4,305	8,388	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	44,218	478,496	188,289	711,003	5.00
7.00	00700 OPERATION OF PLANT	0	258,756	22,638	281,394	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900 HOUSEKEEPING	0	10,576	18	10,594	9.00
10.00	01000 DIETARY	1,826	40,716	17,131	59,673	10.00
11.00	01100 CAFETERIA	0	41,028	0	41,028	11.00
13.00	01300 NURSING ADMINISTRATION	0	6,720	639	7,359	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	23,448	1,016	24,464	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	30,310	2,949	33,259	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	2,240	13,088	15,328	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	15,595	317,788	102,843	436,226	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	279,875	149,140	43,859	472,874	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	71,349	100,145	335,657	507,151	54.00
60.00	06000 LABORATORY	19,476	41,765	24,369	85,610	60.00
65.00	06500 RESPIRATORY THERAPY	17,178	90,618	22,104	129,900	65.00
66.00	06600 PHYSICAL THERAPY	0	185,064	22,688	207,752	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	14,035	0	14,035	67.00
69.00	06900 ELECTROCARDIOLOGY	0	85,827	17,200	103,027	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	87,606	18,260	10,847	116,713	73.00
76.00	03550 BEHAVIORAL HEALTH	0	37,370	961	38,331	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - CARLINVILLE	0	167,372	4,643	172,015	88.00
88.01	08801 RHC - GIRARD	25,638	0	0	25,638	88.01
90.00	09000 CLINIC	0	72,387	1,918	74,305	90.00
91.00	09100 EMERGENCY	0	62,605	10,877	73,482	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	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600 HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	562,761	2,238,749	848,039	3,649,549	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,189	19	5,208	190.00
194.00	07950 NONREIMBURSABLE COSTS CENTERS	0	0	0	0	194.00
194.01	07951 FUND DEVELOPMENT	0	1,730	301	2,031	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	562,761	2,245,668	848,359	3,656,788	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	712,276				5.00
7.00	00700	OPERATION OF PLANT	39,986	321,611			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,762	0	10,762		8.00
9.00	00900	HOUSEKEEPING	15,661	2,261	0	28,744	9.00
10.00	01000	DIETARY	16,257	8,705	0	745	10.00
11.00	01100	CAFETERIA	1,438	8,771	0	750	11.00
13.00	01300	NURSING ADMINISTRATION	15,501	1,437	0	123	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	11,504	5,013	0	429	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,895	6,480	0	554	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	5,536	479	0	41	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	66,315	67,939	5,063	5,812	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,143	31,885	895	2,728	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,999	21,410	989	1,832	54.00
60.00	06000	LABORATORY	59,297	8,929	0	764	60.00
65.00	06500	RESPIRATORY THERAPY	26,535	19,373	75	1,658	65.00
66.00	06600	PHYSICAL THERAPY	49,773	39,565	881	3,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,035	3,001	0	257	67.00
69.00	06900	ELECTROCARDIOLOGY	9,434	18,349	0	1,570	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,558	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,475	3,904	0	334	73.00
76.00	03550	BEHAVIORIAL HEALTH	9,597	7,989	0	684	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	86,342	35,782	6	3,062	88.00
88.01	08801	RHC - GIRARD	10,413	0	0	1,420	88.01
90.00	09000	CLINIC	17,104	15,476	0	1,324	90.00
91.00	09100	EMERGENCY	89,786	13,384	2,853	1,145	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)	709,346	320,132	10,762	28,617	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	1,109	0	95	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	2,044	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	703	370	0	32	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	712,276	321,611	10,762	28,744	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	14.00	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	109,566					11.00
13.00	01300 NURSING ADMINISTRATION	3,011	27,674				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	1,833	0	43,312			14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	5,656	0	0	59,007		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	1,030	578	0	0	23,172	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	21,130	11,840	0	3,059		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,309	2,975	0	3,944		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	460		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,499	0	0	16,070		54.00
60.00	06000 LABORATORY	12,550	0	0	11,723		60.00
65.00	06500 RESPIRATORY THERAPY	7,459	0	0	1,073		65.00
66.00	06600 PHYSICAL THERAPY	12,897	0	0	5,497		66.00
67.00	06700 OCCUPATIONAL THERAPY	2,704	0	0	1,195		67.00
69.00	06900 ELECTROCARDIOLOGY	1,922	0	0	1,228		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	43,312	1,307		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	95		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,942	1,650	0	4,147		73.00
76.00	03550 BEHAVIORIAL HEALTH	1,971	1,104	0	279		76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	0	0	0	2,430		88.00
88.01	08801 RHC - GIRARD	0	0	0	286		88.01
90.00	09000 CLINIC	4,755	2,664	0	317		90.00
91.00	09100 EMERGENCY	13,907	6,863	0	5,897		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)	108,575	27,674	43,312	59,007	0	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	991	0	0	0		194.01
200.00	Cross Foot Adjustments					23,172	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	109,566	27,674	43,312	59,007	23,172	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet B
Part II
Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	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
14.00	01400	CENTRAL SERVICE & SUPPLY			14.00
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	646,038	0	646,038
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	558,014	0	558,014
53.00	05300	ANESTHESIOLOGY	460	0	460
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,358	0	621,358
60.00	06000	LABORATORY	179,379	0	179,379
65.00	06500	RESPIRATORY THERAPY	186,415	0	186,415
66.00	06600	PHYSICAL THERAPY	320,424	0	320,424
67.00	06700	OCCUPATIONAL THERAPY	32,398	0	32,398
69.00	06900	ELECTROCARDIOLOGY	135,607	0	135,607
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,619	0	44,619
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,653	0	1,653
73.00	07300	DRUGS CHARGED TO PATIENTS	171,338	0	171,338
76.00	03550	BEHAVIORAL HEALTH	60,036	0	60,036
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	300,808	0	300,808
88.01	08801	RHC - GIRARD	37,899	0	37,899
90.00	09000	CLINIC	116,141	0	116,141
91.00	09100	EMERGENCY	208,253	0	208,253
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,620,840	0	3,620,840
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,595	0	6,595
194.00	07950	NONREIMBURSABLE COSTS CENTERS	2,044	0	2,044
194.01	07951	FUND DEVELOPMENT	4,137	0	4,137
200.00		Cross Foot Adjustments	23,172	0	23,172
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	3,656,788	0	3,656,788

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet B-1

Date/Time Prepared:
12/22/2020 8:49 am

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		790,787			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144	4,013	11,552,734		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,876	175,511	1,752,783	-5,338,303	5.00
7.00	00700	OPERATION OF PLANT	9,126	21,102	317,854	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	373	17	314,256	0	9.00
10.00	01000	DIETARY	1,436	15,968	203,545	0	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	237	596	334,732	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	827	947	95,304	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	2,749	224,264	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	12,200	247,992	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,208	95,864	971,459	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,260	40,883	360,154	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	312,876	562,620	0	54.00
60.00	06000	LABORATORY	1,473	22,715	696,302	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	20,604	470,474	0	65.00
66.00	06600	PHYSICAL THERAPY	6,527	21,148	928,659	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	234,872	0	67.00
69.00	06900	ELECTROCARDIOLOGY	3,027	16,033	105,664	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	644	10,111	238,231	0	73.00
76.00	03550	BEHAVIORAL HEALTH	1,318	896	111,969	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	5,903	4,328	1,612,589	0	88.00
88.01	08801	RHC - GIRARD	0	0	196,104	0	88.01
90.00	09000	CLINIC	2,553	1,788	269,703	0	90.00
91.00	09100	EMERGENCY	2,208	10,139	1,288,824	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	790,488	11,538,354	-5,338,303	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	14,380	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)	2,245,668	848,359	2,924,291	5,338,303	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.353678	1.072803	0.253125	0.262652	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,388	712,276	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000726	0.035045	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 08/01/2019
To 07/31/2020

Worksheet B-1

Date/Time Prepared:
12/22/2020 8:49 am

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	55,421			9.00
10.00	01000	DIETARY	1,436	0	1,436	31,122		10.00
11.00	01100	CAFETERIA	1,447	0	1,447	20,952	11,061	11.00
13.00	01300	NURSING ADMINISTRATION	237	0	237	0	304	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	827	0	827	0	185	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	0	1,069	0	571	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	104	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,208	55,650	11,208	10,170	2,133	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,260	9,834	5,260	0	536	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	10,866	3,532	0	959	54.00
60.00	06000	LABORATORY	1,473	0	1,473	0	1,267	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	827	3,196	0	753	65.00
66.00	06600	PHYSICAL THERAPY	6,527	9,689	6,527	0	1,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	495	0	273	67.00
69.00	06900	ELECTROCARDIOLOGY	3,027	0	3,027	0	194	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	0	644	0	297	73.00
76.00	03550	BEHAVIORIAL HEALTH	1,318	0	1,318	0	199	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	5,903	67	5,903	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	2,738	0	0	88.01
90.00	09000	CLINIC	2,553	0	2,553	0	480	90.00
91.00	09100	EMERGENCY	2,208	31,360	2,208	0	1,404	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)	52,812	118,293	55,177	31,122	10,961	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	0	183	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	0	61	0	100	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)	1,440,659	387,758	574,392	639,606	536,689	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.153555	3.277945	10.364158	20.551571	48.520839	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	321,611	10,762	28,744	85,528	109,566	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.061727	0.090977	0.518648	2.748152	9.905614	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 08/01/2019
To 07/31/2020

Worksheet B-1

Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	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	103,724			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	100		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	48,034,067	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,165	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,373	0	2,491,053	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,151	0	3,212,044	50.00
53.00	05300	ANESTHESIOLOGY	0	0	374,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	13,071,315	54.00
60.00	06000	LABORATORY	0	0	9,546,255	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	873,494	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,476,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	972,870	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	999,649	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	1,064,165	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	77,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,186	0	3,377,324	73.00
76.00	03550	BEHAVIORIAL HEALTH	4,139	0	226,878	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	1,978,421	88.00
88.01	08801	RHC - GIRARD	0	0	232,752	88.01
90.00	09000	CLINIC	9,986	0	257,873	90.00
91.00	09100	EMERGENCY	25,724	0	4,802,408	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	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,724	100	48,034,067	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)	582,146	454,484	532,411	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.612452	4,544.840000	0.011084	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,674	43,312	59,007	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.266804	433.120000	0.001228	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			231.720000	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 08/01/2019
To 07/31/2020Worksheet C
Part I
Date/Time Prepared:
12/22/2020 8:49 am

		Title XVIII		Hospital		Cost
Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3,581,376		3,581,376	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,692,002		1,692,002	0	0 50.00
53.00	05300 ANESTHESIOLOGY	223,774		223,774	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,665,409		2,665,409	0	0 54.00
60.00	06000 LABORATORY	2,358,972		2,358,972	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	1,124,862	0	1,124,862	0	0 65.00
66.00	06600 PHYSICAL THERAPY	2,182,727	0	2,182,727	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	440,167	0	440,167	0	0 67.00
69.00	06900 ELECTROCARDIOLOGY	473,965		473,965	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	466,279		466,279	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	56,993		56,993	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,605,056		1,605,056	0	0 73.00
76.00	03550 BEHAVIORIAL HEALTH	430,625		430,625	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - CARLINVILLE	3,354,458		3,354,458	0	0 88.00
88.01	08801 RHC - GIRARD	406,135		406,135	0	0 88.01
90.00	09000 CLINIC	794,222		794,222	0	0 90.00
91.00	09100 EMERGENCY	3,686,288		3,686,288	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	526,084		526,084	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)	26,069,394	0	26,069,394	0	0 200.00
201.00	Less observation Beds	526,084		526,084		0 201.00
202.00	Total (see instructions)	25,543,310	0	25,543,310	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet C
Part I
Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Title XVIII			Hospital	Cost	
		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	1,772,333		1,772,333			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	75,148	3,136,896	3,212,044	0.526768	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	9,900	364,389	374,289	0.597864	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	567,891	12,503,424	13,071,315	0.203913	0.000000	54.00
60.00	06000 LABORATORY	811,004	8,735,251	9,546,255	0.247110	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	195,401	678,093	873,494	1.287773	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	542,186	3,934,068	4,476,254	0.487624	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	351,487	621,383	972,870	0.452442	0.000000	67.00
69.00	06900 ELECTROCARDIOLOGY	23,828	975,821	999,649	0.474131	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	410,540	653,625	1,064,165	0.438164	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	77,023	77,023	0.739948	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,228,175	2,149,149	3,377,324	0.475245	0.000000	73.00
76.00	03550 BEHAVIORAL HEALTH	0	226,878	226,878	1.898047	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	0	1,978,421	1,978,421			88.00
88.01	08801 RHC - GIRARD	0	232,752	232,752			88.01
90.00	09000 CLINIC	41,706	216,167	257,873	3.079896	0.000000	90.00
91.00	09100 EMERGENCY	94,767	4,707,641	4,802,408	0.767592	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	38,304	680,416	718,720	0.731974	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)	6,162,670	41,871,397	48,034,067			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	6,162,670	41,871,397	48,034,067			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet C
Part I
Date/Time Prepared:
12/22/2020 8:49 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 08/01/2019
To 07/31/2020Worksheet D
Part II
Date/Time Prepared:
12/22/2020 8:49 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	558,014	3,212,044	0.173726	17,889		3,108	50.00
53.00	05300 ANESTHESIOLOGY	460	374,289	0.001229	3,982		5	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	621,358	13,071,315	0.047536	280,660		13,341	54.00
60.00	06000 LABORATORY	179,379	9,546,255	0.018791	284,867		5,353	60.00
65.00	06500 RESPIRATORY THERAPY	186,415	873,494	0.213413	91,877		19,608	65.00
66.00	06600 PHYSICAL THERAPY	320,424	4,476,254	0.071583	68,842		4,928	66.00
67.00	06700 OCCUPATIONAL THERAPY	32,398	972,870	0.033301	34,702		1,156	67.00
69.00	06900 ELECTROCARDIOLOGY	135,607	999,649	0.135655	10,132		1,374	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44,619	1,064,165	0.041929	132,555		5,558	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,653	77,023	0.021461	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	171,338	3,377,324	0.050732	384,077		19,485	73.00
76.00	03550 BEHAVIORIAL HEALTH	60,036	226,878	0.264618	0		0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RHC - CARLINVILLE	300,808	1,978,421	0.152044	0		0	88.00
88.01	08801 RHC - GIRARD	37,899	232,752	0.162830	0		0	88.01
90.00	09000 CLINIC	116,141	257,873	0.450381	25,173		11,337	90.00
91.00	09100 EMERGENCY	208,253	4,802,408	0.043364	5,363		233	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	94,899	718,720	0.132039	140		18	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES							95.00
200.00	Total (lines 50 through 199)	3,069,701	46,261,734		1,340,259		85,504	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet D
Part IV
Date/Time Prepared:
12/22/2020 8:49 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	0	50.00
53.00	05300	ANESTHESIOLOGY	219,625	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	219,625	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet D
Part IV
Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Title XVIII		Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		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)		
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	3,212,044	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	0	219,625	0	374,289	0.586779	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	13,071,315	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	9,546,255	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	873,494	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	4,476,254	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	972,870	0.000000	67.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	999,649	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,064,165	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,023	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,377,324	0.000000	73.00
76.00	03550 BEHAVIORIAL HEALTH	0	0	0	226,878	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	0	0	0	1,978,421	0.000000	88.00
88.01	08801 RHC - GIRARD	0	0	0	232,752	0.000000	88.01
90.00	09000 CLINIC	0	0	0	257,873	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	4,802,408	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	718,720	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	219,625	0	46,261,734		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet D
Part IV
Date/Time Prepared:
12/22/2020 8:49 am

			Title XVIII		Hospital		Cost	
Cost Center Description			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	17,889	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,982	2,337	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	280,660	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	284,867	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	91,877	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	68,842	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	34,702	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,132	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	132,555	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	384,077	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	25,173	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	5,363	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	140	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)			1,340,259	2,337	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet D
Part V
Date/Time Prepared:
12/22/2020 8:49 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.526768	0	1,235,417	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.597864	0	162,507	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203913	0	5,255,190	0	0	54.00
60.00	06000 LABORATORY	0.247110	0	3,558,425	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1.287773	0	344,967	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.487624	0	1,574,683	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.452442	0	157,105	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.474131	0	465,114	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438164	0	243,381	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.739948	0	56,367	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.475245	0	1,302,401	812	0	73.00
76.00	03550 BEHAVIORAL HEALTH	1.898047	0	226,878	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE						88.00
88.01	08801 RHC - GIRARD						88.01
90.00	09000 CLINIC	3.079896	0	149,520	0	0	90.00
91.00	09100 EMERGENCY	0.767592	0	1,670,031	141	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.731974	0	393,688	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000		0			95.00
200.00	Subtotal (see instructions)		0	16,795,674	953	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	16,795,674	953	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet D
Part V
Date/Time Prepared:
12/22/2020 8:49 am

			Title XVIII	Hospital	Cost
Cost Center Description		Costs			
		Cost	Cost		
		Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	650,778	0	50.00
53.00	05300	ANESTHESIOLOGY	97,157	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,071,602	0	54.00
60.00	06000	LABORATORY	879,322	0	60.00
65.00	06500	RESPIRATORY THERAPY	444,239	0	65.00
66.00	06600	PHYSICAL THERAPY	767,853	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,081	0	67.00
69.00	06900	ELECTROCARDIOLOGY	220,525	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,641	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,709	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	618,960	386	73.00
76.00	03550	BEHAVORIAL HEALTH	430,625	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE			88.00
88.01	08801	RHC - GIRARD			88.01
90.00	09000	CLINIC	460,506	0	90.00
91.00	09100	EMERGENCY	1,281,902	108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	288,169	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	7,431,069	494	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	7,431,069	494	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 THROUGH COSTS

Provider CCN: 14-1347

Period:

Worksheet D

Component CCN: 14-2347

From 08/01/2019
To 07/31/2020Part IV
Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description			Title XVIII			Swing Beds - SNF	Cost	
			Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Anesthetist	Post-Stepdown	Post-Stepdown	Post-Stepdown	Post-Stepdown	
		Cost	Adjustments	Adjustments	Adjustments	Adjustments		
		1.00	2A	2.00	3A	3.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	219,625	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	219,625	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347

Period:

Worksheet D

Component CCN: 14-Z347

From 08/01/2019
To 07/31/2020Part IV
Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Title XVIII		Swing Beds - SNF		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		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)		
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	3,212,044	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	0	219,625	0	374,289	0.586779	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	13,071,315	0.000000	54.00
60.00	06000 LABORATORY	0	0	0	9,546,255	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	873,494	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	4,476,254	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	972,870	0.000000	67.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	999,649	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,064,165	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,023	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,377,324	0.000000	73.00
76.00	03550 BEHAVIORIAL HEALTH	0	0	0	226,878	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	0	0	0	1,978,421	0.000000	88.00
88.01	08801 RHC - GIRARD	0	0	0	232,752	0.000000	88.01
90.00	09000 CLINIC	0	0	0	257,873	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	4,802,408	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	718,720	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	219,625	0	46,261,734		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347

Period:

Worksheet D

Component CCN: 14-Z347

From 08/01/2019
To 07/31/2020Part IV
Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Title XVIII					Swing Beds - SNF	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	23,762	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	3,225	1,892	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	141,181	0	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	283,336	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	62,498	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	408,695	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	267,466	0	0	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,874	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	169,503	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	494,756	0	0	0	0	73.00
76.00	03550 BEHAVIORAL HEALTH	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RHC - CARLINVILLE	0.000000	0	0	0	0	0	88.00
88.01	08801 RHC - GIRARD	0.000000	0	0	0	0	0	88.01
90.00	09000 CLINIC	0.000000	10,700	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	7,375	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES							95.00
200.00	Total (lines 50 through 199)		1,876,371	1,892	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:

Worksheet D

Component CCN: 14-Z347

From 08/01/2019
To 07/31/2020Part V
Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Title XVIII				Swing Beds - SNF		Cost	
		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (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	0.526768	0	0	0	0	0	50.00	
53.00	05300 ANESTHESIOLOGY	0.597864	0	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203913	0	0	0	0	0	54.00	
60.00	06000 LABORATORY	0.247110	0	0	0	0	0	60.00	
65.00	06500 RESPIRATORY THERAPY	1.287773	0	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.487624	0	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.452442	0	0	0	0	0	67.00	
69.00	06900 ELECTROCARDIOLOGY	0.474131	0	0	0	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438164	0	0	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.739948	0	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.475245	0	0	0	0	0	73.00	
76.00	03550 BEHAVIORIAL HEALTH	1.898047	0	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800 RHC - CARLINVILLE							88.00	
88.01	08801 RHC - GIRARD							88.01	
90.00	09000 CLINIC	3.079896	0	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0.767592	0	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.731974	0	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

Period:

Worksheet D

Component CCN: 14-Z347

From 08/01/2019

Part V

To 07/31/2020

Date/Time Prepared:

12/22/2020 8:49 am

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description			Costs		
			Cost	Cost	
			Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 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			88.00
88.01	08801	RHC - GIRARD			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 08/01/2019 To 07/31/2020	Worksheet D-1 Date/Time Prepared: 12/22/2020 8:49 am
Cost Center Description		Title XVIII	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,644 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,225 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)			841 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			632 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)			753 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			25 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)			9 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			521 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)			562 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)			677 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			164.87 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			169.82 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,581,376 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			4,122 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)			1,528 25.00
26.00	Total swing-bed cost (see instructions)			1,903,114 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,678,262 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)			1,678,262 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)			1,370.01 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			713,775 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)			713,775 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet D-1

Date/Time Prepared:
12/22/2020 8:49 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)					634,179	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,347,954	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)					769,946	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					927,497	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,697,443	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)					384	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,370.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					526,084	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet D-1

Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Title XVIII		Hospital		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	646,038	3,581,376	0.180388	526,084	94,899	90.00
91.00	Nursing School cost	0	3,581,376	0.000000	526,084	0	91.00
92.00	Allied health cost	0	3,581,376	0.000000	526,084	0	92.00
93.00	All other Medical Education	0	3,581,376	0.000000	526,084	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1347	Period: From 08/01/2019 To 07/31/2020	Worksheet D-3 Date/Time Prepared: 12/22/2020 8:49 am	
Cost Center Description		Title XVIII Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		528,803		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.526768	17,889	9,423	50.00
53.00	05300 ANESTHESIOLOGY	0.597864	3,982	2,381	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203913	280,660	57,230	54.00
60.00	06000 LABORATORY	0.247110	284,867	70,393	60.00
65.00	06500 RESPIRATORY THERAPY	1.287773	91,877	118,317	65.00
66.00	06600 PHYSICAL THERAPY	0.487624	68,842	33,569	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.452442	34,702	15,701	67.00
69.00	06900 ELECTROCARDIOLOGY	0.474131	10,132	4,804	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438164	132,555	58,081	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.739948	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.475245	384,077	182,531	73.00
76.00	03550 BEHAVIORAL HEALTH	1.898047	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	3.079896	25,173	77,530	90.00
91.00	09100 EMERGENCY	0.767592	5,363	4,117	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.731974	140	102	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)		1,340,259	634,179	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)		1,340,259		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1347 Component CCN: 14-Z347	Period: From 08/01/2019 To 07/31/2020	Worksheet D-3 Date/Time Prepared: 12/22/2020 8:49 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		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	0.526768	23,762	12,517	50.00
53.00	05300 ANESTHESIOLOGY	0.597864	3,225	1,928	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203913	141,181	28,789	54.00
60.00	06000 LABORATORY	0.247110	283,336	70,015	60.00
65.00	06500 RESPIRATORY THERAPY	1.287773	62,498	80,483	65.00
66.00	06600 PHYSICAL THERAPY	0.487624	408,695	199,289	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.452442	267,466	121,013	67.00
69.00	06900 ELECTROCARDIOLOGY	0.474131	3,874	1,837	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438164	169,503	74,270	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.739948	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.475245	494,756	235,130	73.00
76.00	03550 BEHAVIORIAL HEALTH	1.898047	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	3.079896	10,700	32,955	90.00
91.00	09100 EMERGENCY	0.767592	7,375	5,661	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.731974	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)		1,876,371	863,887	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)		1,876,371		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1347	Period: From 08/01/2019 To 07/31/2020	Worksheet E Part B Date/Time Prepared: 12/22/2020 8:49 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,431,563 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)			7,431,563 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 charge basis 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)			7,505,879 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)			54,101 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,608,276 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)			4,843,502 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)			4,843,502 30.00
31.00	Primary payer payments			167 31.00
32.00	Subtotal (line 30 minus line 31)			4,843,335 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)			316,194 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			205,526 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			316,194 36.00
37.00	Subtotal (see instructions)			5,048,861 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)			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)			5,048,861 40.00
40.01	Sequestration adjustment (see instructions)			75,733 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			4,784,388 41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)			188,740 43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
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 08/01/2019
To 07/31/2020Worksheet E-1
Part I
Date/Time Prepared:
12/22/2020 8:49 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		1,012,708		4,413,333	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	07/16/2020	235,498	07/16/2020	380,315	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	03/10/2020	41,034	03/10/2020	9,260	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)		194,464		371,055	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)		1,207,172		4,784,388	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		188,740	6.01
6.02	SETTLEMENT TO PROGRAM		26,527		0	6.02
7.00	Total Medicare program liability (see instructions)		1,180,645		4,973,128	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 08/01/2019

Part I

To 07/31/2020

Date/Time Prepared:

12/22/2020 8:49 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		2,189,387		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	07/16/2020	225,653		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	03/10/2020	10,400		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)		215,253		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)		2,404,640		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		107,193		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,511,833		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020Worksheet E-1
Part II
Date/Time Prepared:
12/22/2020 8:49 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: From 08/01/2019 To 07/31/2020	Worksheet E-2	
		Component CCN: 14-Z347		Date/Time Prepared: 12/22/2020 8:49 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)		1,714,417	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 and swing-bed pass-through, see instructions)		874,418	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,239	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)		2,588,835	0	8.00
9.00	Primary payer payments (see instructions)		1,268	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,587,567	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)		2,587,567	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		37,483	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,550,084	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)		2,550,084	0	19.00
19.01	Sequestration adjustment (see instructions)		38,251	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		2,404,640	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		107,193	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
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 08/01/2019 To 07/31/2020	Worksheet E-3 Part V Date/Time Prepared: 12/22/2020 8:49 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,347,954	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)		1,347,954	4.00
5.00	Primary payer payments		2,279	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,359,155	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)		1,359,155	19.00
20.00	Deductibles (exclude professional component)		175,616	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,183,539	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,183,539	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23,207	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		15,085	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,207	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,198,624	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)		1,198,624	30.00
30.01	Sequestration adjustment (see instructions)		17,979	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,207,172	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-26,527	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
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 08/01/2019 To 07/31/2020		Worksheet G Date/Time Prepared: 12/22/2020 8:49 am	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund		
		1.00	2.00	3.00	4.00		
1.00	CURRENT ASSETS						
2.00	Cash on hand in banks	15,988,584	0	0	0	1.00	
3.00	Temporary investments	648,502	0	0	0	2.00	
4.00	Notes receivable	0	0	0	0	3.00	
5.00	Accounts receivable	3,422,302	0	0	0	4.00	
6.00	Other receivable	470,949	0	0	0	5.00	
7.00	Allowances for uncollectible notes and accounts receivable	-857,000	0	0	0	6.00	
8.00	Inventory	296,311	0	0	0	7.00	
9.00	Prepaid expenses	241,411	0	0	0	8.00	
10.00	Other current assets	0	0	0	0	9.00	
11.00	Due from other funds	0	0	0	0	10.00	
12.00	Total current assets (sum of lines 1-10)	20,211,059	0	0	0	11.00	
13.00	FIXED ASSETS						
14.00	Land	500,172	0	0	0	12.00	
15.00	Land improvements	2,510,089	0	0	0	13.00	
16.00	Accumulated depreciation	-1,108,752	0	0	0	14.00	
17.00	Buildings	26,152,932	0	0	0	15.00	
18.00	Accumulated depreciation	-13,030,466	0	0	0	16.00	
19.00	Leasehold improvements	0	0	0	0	17.00	
20.00	Accumulated depreciation	0	0	0	0	18.00	
21.00	Fixed equipment	0	0	0	0	19.00	
22.00	Accumulated depreciation	0	0	0	0	20.00	
23.00	Automobiles and trucks	0	0	0	0	21.00	
24.00	Accumulated depreciation	0	0	0	0	22.00	
25.00	Major movable equipment	9,936,276	0	0	0	23.00	
26.00	Accumulated depreciation	-6,647,784	0	0	0	24.00	
27.00	Minor equipment depreciable	0	0	0	0	25.00	
28.00	Accumulated depreciation	0	0	0	0	26.00	
29.00	HIT designated Assets	1,180,327	0	0	0	27.00	
30.00	Accumulated depreciation	-937,416	0	0	0	28.00	
31.00	Minor equipment-nondepreciable	0	0	0	0	29.00	
32.00	Total fixed assets (sum of lines 12-29)	18,555,378	0	0	0	30.00	
33.00	OTHER ASSETS						
34.00	Investments	5,985,009	0	0	0	31.00	
35.00	Deposits on leases	0	0	0	0	32.00	
36.00	Due from owners/officers	0	0	0	0	33.00	
37.00	Other assets	0	0	0	0	34.00	
38.00	Total other assets (sum of lines 31-34)	5,985,009	0	0	0	35.00	
39.00	Total assets (sum of lines 11, 30, and 35)	44,751,446	0	0	0	36.00	
40.00	CURRENT LIABILITIES						
41.00	Accounts payable	707,473	0	0	0	37.00	
42.00	Salaries, wages, and fees payable	598,266	0	0	0	38.00	
43.00	Payroll taxes payable	40,042	0	0	0	39.00	
44.00	Notes and loans payable (short term)	957,489	0	0	0	40.00	
45.00	Deferred income	113,523	0	0	0	41.00	
46.00	Accelerated payments	9,942,459	0	0	0	42.00	
47.00	Due to other funds	0	0	0	0	43.00	
48.00	Other current liabilities	2,895,637	0	0	0	44.00	
49.00	Total current liabilities (sum of lines 37 thru 44)	15,254,889	0	0	0	45.00	
50.00	LONG TERM LIABILITIES						
51.00	Mortgage payable	0	0	0	0	46.00	
52.00	Notes payable	13,792,661	0	0	0	47.00	
53.00	Unsecured loans	0	0	0	0	48.00	
54.00	Other long term liabilities	0	0	0	0	49.00	
55.00	Total long term liabilities (sum of lines 46 thru 49)	13,792,661	0	0	0	50.00	
56.00	Total liabilities (sum of lines 45 and 50)	29,047,550	0	0	0	51.00	
57.00	CAPITAL ACCOUNTS						
58.00	General fund balance	15,703,896	0	0	0	52.00	
59.00	Specific purpose fund	0	0	0	0	53.00	
60.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00	
61.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00	
62.00	Governing body created - endowment fund balance	0	0	0	0	56.00	
63.00	Plant fund balance - invested in plant	0	0	0	0	57.00	
64.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00	
65.00	Total fund balances (sum of lines 52 thru 58)	15,703,896	0	0	0	59.00	
66.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,751,446	0	0	0	60.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet G-1

Date/Time Prepared:
12/22/2020 8:49 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,283,690		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,573,598				2.00
3.00	Total (sum of line 1 and line 2)		15,710,092		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)		15,710,092		0		11.00
12.00	DECREASE IN PERM RESTRICTED	6,196		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)		6,196		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,703,896		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 08/01/2019
To 07/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
12/22/2020 8:49 am

Cost Center Description		Inpatient 1.00	Outpatient 2.00	Total 3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,663,741		1,663,741	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	690,799		690,799	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)	2,354,540		2,354,540	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)	2,354,540		2,354,540	17.00
18.00	Ancillary services	4,166,575	0	4,166,575	18.00
19.00	Outpatient services	0	42,770,014	42,770,014	19.00
20.00	RHC - CARLINVILLE	0	1,978,421	1,978,421	20.00
20.01	RHC - GIRARD	0	232,752	232,752	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)	6,521,115	44,981,187	51,502,302	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		28,323,629		29.00
30.00	DEDUCT (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	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		28,323,629		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2019
To 07/31/2020

Worksheet G-3

Date/Time Prepared:
12/22/2020 8:49 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	51,502,302	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,696,651	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,805,651	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	28,323,629	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,517,978	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	40,279	6.00
7.00	Income from investments	342,556	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	20,091	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	83,380	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	244,223	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	18,265	24.01
24.02	BUSINESS INTERRUPTION PROCEEDS	326,701	24.02
24.03	OTHER	103,676	24.03
24.04	340B REVENUE	554,929	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	186,914	24.05
24.06	GRANTS	23,366	24.06
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,944,380	25.00
26.00	Total (line 5 plus line 25)	-1,573,598	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)	-1,573,598	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8530

From 08/01/2019
To 07/31/2020Date/Time Prepared:
12/22/2020 8:49 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification	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	689,937	0	689,937	0	689,937 1.00
2.00	Physician Assistant	75,632	0	75,632	0	75,632 2.00
3.00	Nurse Practitioner	99,372	0	99,372	0	99,372 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	0	0	0	0	0 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	949,729	0	949,729	-202,081	747,648 9.00
10.00	Subtotal (sum of lines 1 through 9)	1,814,670	0	1,814,670	-202,081	1,612,589 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	76,415	76,415	0	76,415 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	62,039	62,039	0	62,039 18.00
19.00	Other Health Care Costs	0	120,354	120,354	12,138	132,492 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	258,808	258,808	12,138	270,946 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,814,670	258,808	2,073,478	-189,943	1,883,535 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0 29.00
30.00	Administrative Costs	0	0	0	0	0 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,814,670	258,808	2,073,478	-189,943	1,883,535 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8530

From 08/01/2019
To 07/31/2020Date/Time Prepared:
12/22/2020 8:49 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	689,937		1.00
2.00	Physician Assistant	0	75,632		2.00
3.00	Nurse Practitioner	0	99,372		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	747,648		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,612,589		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	76,415		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	62,039		18.00
19.00	Other Health Care Costs	0	132,492		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	270,946		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,883,535		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,883,535		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8532

From 08/01/2019
To 07/31/2020Date/Time Prepared:
12/22/2020 8:49 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	1 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	42,640	0	42,640	0	42,640 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	90,295	0	90,295	0	90,295 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	0	0	0	0	0 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	101,266	0	101,266	-38,097	63,169 9.00
10.00	Subtotal (sum of lines 1 through 9)	234,201	0	234,201	-38,097	196,104 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	4,437	4,437	0	4,437 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	13,613	13,613	0	13,613 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,050	18,050	0	18,050 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	234,201	18,050	252,251	-38,097	214,154 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	33,342	33,342	0	33,342 29.00
30.00	Administrative Costs	0	0	0	0	0 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	33,342	33,342	0	33,342 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	234,201	51,392	285,593	-38,097	247,496 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8532

From 08/01/2019
To 07/31/2020Date/Time Prepared:
12/22/2020 8:49 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	42,640	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	90,295	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	63,169	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	196,104	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	4,437	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	13,613	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,050	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	214,154	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	33,342	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	33,342	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	247,496	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347

Period:

Worksheet M-2

Component CCN: 14-8530

From 08/01/2019
To 07/31/2020Date/Time Prepared:
12/22/2020 8:49 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	2.75	9,038	3,310	9,103		1.00
2.00	Physician Assistant	0.65	836	1,655	1,076		2.00
3.00	Nurse Practitioner	0.97	1,925	1,655	1,605		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.37	11,799		11,784	11,799	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)	4.37	11,799			11,799	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)					1,883,535	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)					1,883,535	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)					1,470,923	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,470,923	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,470,923	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,470,923	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,354,458	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347

Period:

Worksheet M-2

Component CCN: 14-8532

From 08/01/2019
To 07/31/2020Date/Time Prepared:
12/22/2020 8:49 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	0.16	165	2,688	430		1.00
2.00	Physician Assistant	0.00	0	1,344	0		2.00
3.00	Nurse Practitioner	0.77	1,299	1,344	1,035		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.93	1,464		1,465	1,465	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)	0.93	1,464			1,465	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)					214,154	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)					214,154	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)					33,342	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					158,639	15.00
16.00	Total overhead (sum of lines 14 and 15)					191,981	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					191,981	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					191,981	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					406,135	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1347	Period: From 08/01/2019 To 07/31/2020	Worksheet M-3 Date/Time Prepared: 12/22/2020 8:49 am	
		Component CCN: 14-8530			
		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)			3,354,458	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			9,654	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,344,804	3.00
4.00	Total visits (from Wkst. M-2, column 5, line 8)			11,799	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)			11,799	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			283.48	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)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		283.48	283.48	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,257	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	639,814	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	639,814	16.00
16.01	Total program charges (see instructions)(from contractor's records)			302,378	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			18,572	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			39,297	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.)			454,273	16.04
16.05	Total program cost (see instructions)		0	493,570	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			32,676	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			50,226	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			493,570	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			9,654	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			503,224	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)			503,224	26.00
26.01	Sequestration adjustment (see instructions)			7,548	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			394,932	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)			100,744	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 08/01/2019 To 07/31/2020	Worksheet M-3 Date/Time Prepared: 12/22/2020 8:49 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)			406,135	1.00
2.00	Cost of vaccines and their administration (from wkst. M-4, line 15)			795	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			405,340	3.00
4.00	Total Visits (from wkst. M-2, column 5, line 8)			1,465	4.00
5.00	Physicians visits under agreement (from wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,465	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			276.68	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)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		276.68	276.68	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	276	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	76,364	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	76,364	16.00
16.01	Total program charges (see instructions)(from contractor's records)			40,693	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,725	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			5,114	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.)			50,999	16.04
16.05	Total program cost (see instructions)		0	56,113	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			7,501	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			6,093	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			56,113	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)			795	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			56,908	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)			56,908	26.00
26.01	Sequestration adjustment (see instructions)			854	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			35,357	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)			20,697	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 08/01/2019 To 07/31/2020	Worksheet M-4 Date/Time Prepared: 12/22/2020 8:49 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)	1,612,589	1,612,589	1.00	
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000048	0.000246	2.00	
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	77	397	3.00	
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,377	2,569	4.00	
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,454	2,966	5.00	
6.00	Total direct cost of the hospital-based RHC/FQHC (from worksheet M-1, col. 7, line 22)	1,883,535	1,883,535	6.00	
7.00	Total overhead (from wkst. M-2, line 19)	1,470,923	1,470,923	7.00	
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001303	0.001575	8.00	
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,917	2,317	9.00	
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,371	5,283	10.00	
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	19	97	11.00	
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	230.05	54.46	12.00	
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	19	97	13.00	
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,371	5,283	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)		9,654	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)		9,654	16.00	

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1347 Component CCN: 14-8532	Period: From 08/01/2019 To 07/31/2020	Worksheet M-4 Date/Time Prepared: 12/22/2020 8:49 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from wkst. M-1, col. 7, line 10)		196,104	196,104	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000021	0.000230	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		4	45	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		183	187	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		187	232	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		214,154	214,154	6.00
7.00	Total overhead (from wkst. M-2, line 19)		191,981	191,981	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000873	0.001083	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		168	208	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		355	440	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		1	11	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		355.00	40.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		1	11	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		355	440	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)			795	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)			795	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 08/01/2019 To 07/31/2020	Worksheet M-5 Date/Time Prepared: 12/22/2020 8:49 am
		RHC I	Cost	
		Part B		
		mm/dd/yyyy 1.00	Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		417,638	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		07/16/2020	27,695	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		03/10/2020	50,401	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)		-22,706	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		394,932	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		100,744	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		495,676	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 08/01/2019 To 07/31/2020	Worksheet M-5 Date/Time Prepared: 12/22/2020 8:49 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		34,947	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		03/10/2020	410	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)		410	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		35,357	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		20,697	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		56,054	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00