

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 08/01/2020 To 07/31/2021	Worksheet S Parts I-III Date/Time Prepared: 12/17/2021 7:00 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 12/17/2021	Time: 7:00 pm
	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 (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARLINVILLE AREA HOSPITAL (14-1347) for the cost reporting period beginning 08/01/2020 and ending 07/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-98,972	-776,899	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	137,671	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RHC - CARLINVILLE I	0		41,773		0	10.00
10.01	RHC - GIRARD II	0		15,897		0	10.01
200.00	Total	0	38,699	-719,229	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1347		Period: From 08/01/2020 To 07/31/2021		Worksheet S-2 Part I Date/Time Prepared: 12/17/2021 7:00 pm		
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 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		CARLINVILLE AREA HOSPITAL	141347	41180	1	07/01/2005	N	O N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF		CARLINVILLE AREA HOSPITAL SWING BED	14Z347	99914		07/01/2005	N	O N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC		CARLINVILLE RHC	148530	99914		11/25/2013	N	O N	15.00
15.01	Hospital-Based Health Clinic - RHC II		GIRARD RHC	148532	99914		02/12/2014	N	O N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					08/01/2020		07/31/2021		20.00
21.00	Type of Control (see instructions)					2				21.00
						1.00		2.00		
						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	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? 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.								22.04	
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 08/01/2020
To 07/31/2021Worksheet S-2
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 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 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347		Period: From 08/01/2020 To 07/31/2021		Worksheet S-2 Part I Date/Time Prepared: 12/17/2021 7:00 pm			
		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			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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 08/01/2020
To 07/31/2021Worksheet S-2
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

	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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
	Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347	Period: From 08/01/2020 To 07/31/2021	Worksheet S-2 Part I Date/Time Prepared: 12/17/2021 7:00 pm	
			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	Y
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347	Period: From 08/01/2020 To 07/31/2021	Worksheet S-2 Part I Date/Time Prepared: 12/17/2021 7:00 pm
		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		0115.00
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:	298,193	0	0118.01
		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 08/01/2020 To 07/31/2021		Worksheet S-2 Part I Date/Time Prepared: 12/17/2021 7:00 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	Y	Y	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	157.00			
158.00	SUBPROVIDER					158.00			
159.00	SNF	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00			
161.00	CMHC		N	N	N	161.00			
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1347	Period: From 08/01/2020 To 07/31/2021	Worksheet S-2 Part II Date/Time Prepared: 12/17/2021 7:00 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/15/2021	Y	11/15/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet S-2
Part II
Date/Time Prepared:
12/17/2021 7:00 pm

		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.		Y		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVE	MILLER		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	SMILLER@CAHCARE.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet S-2
Part II
Date/Time Prepared:
12/17/2021 7:00 pm

		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.	INTERIM 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 08/01/2020
To 07/31/2021Worksheet S-3
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	26,784.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	26,784.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	26,784.00	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 08/01/2020
To 07/31/2021Worksheet S-3
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	684	106	1,116			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	1,110	0	1,385			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	81			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,794	106	2,582			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)	1,794	106	2,582	0.00	168.30	14.00
15.00	CAH visits	14,045	5,249	29,890			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	2,197	3,421	12,775	0.00	21.27	26.00
26.01	RHC - GIRARD	272	431	1,327	0.00	2.63	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	192.20	27.00
28.00	Observation Bed Days		86	433			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 08/01/2020
To 07/31/2021Worksheet S-3
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	209	36	347	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	209	36	347	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
 Component CCN: 14-8530

 Period:
 From 08/01/2020
 To 07/31/2021

Worksheet S-8

 Date/Time Prepared:
 12/17/2021 7:00 pm

		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		1115 EAST MORGAN STREET, #2		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		CARLINVILLE	IL 62626	2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
					1.00 2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		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 13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County		MACOUPIN		2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Facility hours of operations (1)			
11.00	CLINIC	16:00	07:30	16:00	07:30
					16:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1347

Period:

Worksheet S-8

Component CCN: 14-8530

From 08/01/2020

To 07/31/2021

Date/Time Prepared:

12/17/2021 7:00 pm

		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
 Component CCN: 14-8532

 Period:
 From 08/01/2020
 To 07/31/2021

Worksheet S-8

 Date/Time Prepared:
 12/17/2021 7:00 pm

				RHC II		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			205 SOUTH THRID STREET			1.00
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			GIRARD IL 62640		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0	10.00
			Sunday		Monday		Tuesday
			from	to	from	to	from
			1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)							
11.00	CLINIC			08:00		17:00	08:00
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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	Total Visits
			1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
				County			
				4.00			
2.00	City, State, ZIP Code, County			MACOUPIN		2.00	
			Tuesday	Wednesday		Thursday	
			to	from	to	from	to
			6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)							
11.00	CLINIC			17:00	08:00	17:00	08:00
				17:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1347

Period:

Worksheet S-8

Component CCN: 14-8532

From 08/01/2020

To 07/31/2021

Date/Time Prepared:
12/17/2021 7:00 pm

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 08/01/2020
To 07/31/2021

Worksheet S-10

Date/Time Prepared:
12/17/2021 7:00 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.486144	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,377,274	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		1,934,658	5.00
6.00	Medicaid charges		12,128,474	6.00
7.00	Medicaid cost (line 1 times line 6)		5,896,185	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		94,923	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	81,107	0	81,107 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	39,430	0	39,430 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)	39,430	0	39,430 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)		864,712	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		221,158	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		340,242	27.01
28.00	Non-Medicare bad debt expense (see instructions)		524,470	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		374,052	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		413,482	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		413,482	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1347	Period: From 08/01/2020 To 07/31/2021	Worksheet A Date/Time Prepared: 12/17/2021 7:00 pm
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,439,681	2,439,681	-68,952	2,370,729
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	790,698	790,698
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	173,706	3,316,940	0	3,490,646
5.00	00500	ADMINISTRATIVE & GENERAL	1,643,358	3,413,521	133,768	5,190,647
7.00	00700	OPERATION OF PLANT	325,784	509,470	0	835,254
8.00	00800	LAUNDRY & LINEN SERVICE	0	330,506	0	330,506
9.00	00900	HOUSEKEEPING	334,201	48,697	0	382,898
10.00	01000	DIETARY	208,231	270,810	0	479,041
11.00	01100	CAFETERIA	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	300,941	26,702	0	327,643
14.00	01400	CENTRAL SERVICE & SUPPLY	106,117	338,727	0	444,844
16.00	01600	MEDICAL RECORDS & LIBRARY	252,077	56,152	0	308,229
19.00	01900	NONPHYSICIAN ANESTHETISTS	350,730	16,089	0	366,819
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,121,391	454,557	0	1,575,948
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	546,293	1,324,893	0	1,871,186
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	606,630	622,626	4,343	1,233,599
60.00	06000	LABORATORY	797,758	1,679,623	0	2,477,381
65.00	06500	RESPIRATORY THERAPY	493,366	97,802	0	591,168
66.00	06600	PHYSICAL THERAPY	1,111,122	58,360	0	1,169,482
67.00	06700	OCCUPATIONAL THERAPY	265,763	7,747	0	273,510
69.00	06900	ELECTROCARDIOLOGY	123,332	58,190	0	181,522
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,505	0	65,505
73.00	07300	DRUGS CHARGED TO PATIENTS	241,721	1,292,068	0	1,533,789
76.00	03550	BEHAVIORIAL HEALTH	154,056	113,002	0	267,058
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	2,033,009	241,629	-191,350	2,083,288
88.01	08801	RHC - GIRARD	188,600	88,081	-31,600	245,081
90.00	09000	CLINIC	276,340	99,878	0	376,218
91.00	09100	EMERGENCY	1,416,421	2,292,545	0	3,708,966
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	636,907	-636,907	0
116.00	11600	HOSPICE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,070,947	19,900,708	0	32,971,655
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	58,335	0	58,335
194.01	07951	FUND DEVELOPMENT	45,535	0	0	45,535
200.00		TOTAL (SUM OF LINES 118 through 199)	13,116,482	19,959,043	0	33,075,525

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet A

Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-160,558	2,210,171	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-1,550	789,148	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,490,646	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-313,200	4,877,447	5.00
7.00	00700	OPERATION OF PLANT	-51	835,203	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	330,506	8.00
9.00	00900	HOUSEKEEPING	0	382,898	9.00
10.00	01000	DIETARY	-81,429	397,612	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-11	327,632	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	444,844	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,820	301,409	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-162,265	204,554	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,575,948	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-550,202	1,320,984	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,639	1,225,960	54.00
60.00	06000	LABORATORY	0	2,477,381	60.00
65.00	06500	RESPIRATORY THERAPY	-14,602	576,566	65.00
66.00	06600	PHYSICAL THERAPY	-700	1,168,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	273,510	67.00
69.00	06900	ELECTROCARDIOLOGY	-51,180	130,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-223,492	1,310,297	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	267,058	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	2,083,288	88.00
88.01	08801	RHC - GIRARD	0	245,081	88.01
90.00	09000	CLINIC	-32,666	343,552	90.00
91.00	09100	EMERGENCY	-920,116	2,788,850	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)	-2,526,481	30,445,174	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	45,535	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,526,481	30,549,044	200.00

RECLASSIFICATIONS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet A-6

Date/Time Prepared:
12/17/2021 7:00 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - RECLASS RECRUITMENT EXPENSES					1.00
	RHC - CARLINVILLE	88.00	0	29,335		
	TOTALS		0	29,335		
1.00	B - TO RECLASS DEPRECIATION EXPENSE					1.00
	NEW CAP REL COSTS-MVBLE	2.00	0	756,035		
	EQUIP					
	TOTALS		0	756,035		
1.00	C - INSURANCE EXPENSE					1.00
	OTHER CAPITAL RELATED COSTS	3.00	0	119,379		
	TOTALS		0	119,379		
1.00 2.00 3.00	E - INTEREST EXPENSE RECLASS					1.00 2.00 3.00
	RADIOLOGY-DIAGNOSTIC	54.00	0	4,343		
	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	602,367		
	ADMINISTRATIVE & GENERAL	5.00	0	30,197		
	TOTALS		0	636,907		
1.00 2.00 500.00	L - RECLASS RHC ADMIN SALARIES TO ADMIN					1.00 2.00 500.00
	ADMINISTRATIVE & GENERAL	5.00	252,285	0		
		0.00	0	0		
	TOTALS		252,285	0		
	Grand Total: Increases		252,285	1,541,656		

RECLASSIFICATIONS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet A-6

Date/Time Prepared:
12/17/2021 7:00 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RECLASS RECRUITMENT EXPENSES						
	ADMINISTRATIVE & GENERAL	5.00	0	29,335	0		1.00
	TOTALS		0	29,335			
1.00	B - TO RECLASS DEPRECIATION EXPENSE						
	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	756,035	9		1.00
	TOTALS		0	756,035			
1.00	C - INSURANCE EXPENSE						
	ADMINISTRATIVE & GENERAL	5.00	0	119,379	0		1.00
	TOTALS		0	119,379			
1.00	E - INTEREST EXPENSE RECLASS						
	INTEREST EXPENSE	113.00	0	636,907	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	636,907			
1.00	L - RECLASS RHC ADMIN SALARIES TO ADMIN						
	RHC - CARLINVILLE	88.00	220,685	0	0		1.00
2.00	RHC - GIRARD	88.01	31,600	0	0		2.00
	TOTALS		252,285	0			
500.00	Grand Total: Decreases		252,285	1,541,656			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet A-7
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	500,172	0	0	0	0	1.00	
2.00	Land Improvements	2,510,089	13,971	0	13,971	0	2.00	
3.00	Buildings and Fixtures	26,152,932	105,990	0	105,990	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	9,936,279	864,874	0	864,874	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)	40,279,799	984,835	0	984,835	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	40,279,799	984,835	0	984,835	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	500,172	0				1.00	
2.00	Land Improvements	2,524,060	0				2.00	
3.00	Buildings and Fixtures	26,258,922	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	10,801,153	0				6.00	
7.00	HIT designated Assets	1,180,327	0				7.00	
8.00	Subtotal (sum of lines 1-7)	41,264,634	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	41,264,634	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet A-7
Part II
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,439,681	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)	2,439,681	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	2,439,681				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,439,681				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet A-7
Part III
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	29,283,154	0	29,283,154	0.709643	84,716	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	11,981,479	0	11,981,479	0.290357	34,663	2.00
3.00	Total (sum of lines 1-2)	41,264,633	0	41,264,633	1.000000	119,379	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	84,716	2,125,455	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	34,663	754,485	0	2.00
3.00	Total (sum of lines 1-2)	0	0	119,379	2,879,940	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	84,716	0	0	2,210,171	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	34,663	0	0	789,148	2.00
3.00	Total (sum of lines 1-2)	0	119,379	0	0	2,999,319	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet A-8

Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-12,082	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	454	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	-1,464,526			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	-81,429	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	-30,668	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,820	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	-14,602	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet A-8

Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-1,550	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 33.00
33.01	RADIOLOGY DISCOUNTS	B	-7,639	RADIOLOGY-DIAGNOSTIC	54.00		0 33.01
33.02	PT PROF FEES	B	-700	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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 33.04
33.05	SUPPLIES	B	-5,792	OPERATING ROOM	50.00		0 33.05
33.06	AHA & IHA DUES	A	-11,744	ADMINISTRATIVE & GENERAL	5.00		0 33.06
33.07	PLANT OPERATION DISCOUNTS	B	-51	OPERATION OF PLANT	7.00		0 33.07
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 37.00
39.00	MED STAFF RELATIONS	A	-4,814	ADMINISTRATIVE & GENERAL	5.00		0 39.00
40.00	SPECIAL EVENTS - OUTREACH	A	-18,077	ADMINISTRATIVE & GENERAL	5.00		0 40.00
41.00	PROMOTIONAL ITEMS - OUTREACH	A	-16,495	ADMINISTRATIVE & GENERAL	5.00		0 41.00
42.00	ADVERTISING	A	-205,132	ADMINISTRATIVE & GENERAL	5.00		0 42.00
44.00	TELEPHONE DEPRECIATION	A	-1,542	NEW CAP REL COSTS-BLDG & FIXT	1.00		9 44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-1,668	ADMINISTRATIVE & GENERAL	5.00		0 44.01
44.02	SPRINGFIELD CLINIC RENT	B	-32,666	CLINIC	90.00		0 44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,720	ADMINISTRATIVE & GENERAL	5.00		0 44.03
44.04	PPP INTEREST	A	-30,197	ADMINISTRATIVE & GENERAL	5.00		0 44.04
44.05	MOB BUILDING RENT	B	-190,053	NEW CAP REL COSTS-BLDG & FIXT	1.00		9 44.05
44.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 44.06
44.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 44.07
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 45.00
45.01	340B PROGRAM	B	-192,824	DRUGS CHARGED TO PATIENTS	73.00		0 45.01
45.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 45.02
45.03	CRNA COSTS	A	-138,274	NONPHYSICIAN ANESTHETISTS	19.00		0 45.03
45.04	CRNA BENEFITS	A	-23,991	NONPHYSICIAN ANESTHETISTS	19.00		0 45.04
45.05	EKG PROFESSIONAL FEES	A	-51,180	ELECTROCARDIOLOGY	69.00		0 45.05
45.06	PROFESSIONAL BILLING COSTS	A	-20,048	ADMINISTRATIVE & GENERAL	5.00		0 45.06
45.07	NURSING SERVICE DISCOUNTS	B	-11	NURSING ADMINISTRATION	13.00		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
45.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 45.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,526,481				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 08/01/2020
To 07/31/2021

Worksheet A-8-2

Date/Time Prepared:
12/17/2021 7:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,887,235	419,721	1,467,514	0	0	1.00
2.00	91.00	EMERGENCY	425,280	425,280	0	0	0	2.00
3.00	50.00	OPERATING ROOM	544,410	544,410	0	0	0	3.00
4.00	91.00	EMERGENCY	75,115	75,115	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			2,932,040	1,464,526	1,467,514			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	419,721		1.00
2.00	91.00	EMERGENCY	0	0	0	425,280		2.00
3.00	50.00	OPERATING ROOM	0	0	0	544,410		3.00
4.00	91.00	EMERGENCY	0	0	0	75,115		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	1,464,526		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1347		Period: From 08/01/2020 To 07/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/17/2021 7:00 pm	
				Respiratory Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					8	1.00
2.00	Line 1 multiplied by 15 hours per week					120	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					40	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.66	7.00
8.00	Optional travel expense rate per mile					0.57	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	502.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.81	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.91	33.91	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					34,091	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					34,091	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					34,091	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					34,091	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					1,356	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,356	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					226	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,582	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,582	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					226	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1347		Period: From 08/01/2020 To 07/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/17/2021 7:00 pm	
				Respiratory Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.81	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
							1.00
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)						34,091
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						1,582
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0
60.00	Overtime allowance (from column 5, line 56)						0
61.00	Equipment cost (see instructions)						0
62.00	Supplies (see instructions)						0
63.00	Total allowance (sum of lines 57-62)						35,673
64.00	Total cost of outside supplier services (from your records)						50,275
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						14,602
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,356
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						226
100.02	Line 33 = line 28 = sum of lines 26 and 27						1,582
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						226
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
101.02	Line 34 = sum of lines 27 and 31						226
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0
102.02	Line 35 = sum of lines 31 and 32						0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,210,171	2,210,171				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	789,148		789,148			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,490,646	4,018	747	3,495,411		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,877,447	485,388	172,776	511,942	6,047,553	5.00
7.00	00700	OPERATION OF PLANT	835,203	254,666	4,298	87,984	1,182,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	330,506	0	0	0	330,506	8.00
9.00	00900	HOUSEKEEPING	382,898	10,409	882	90,257	484,446	9.00
10.00	01000	DIETARY	397,612	40,072	6,759	56,236	500,679	10.00
11.00	01100	CAFETERIA	0	40,379	0	0	40,379	11.00
13.00	01300	NURSING ADMINISTRATION	327,632	17,413	630	81,274	426,949	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	444,844	23,078	0	28,659	496,581	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	301,409	10,772	3,005	68,078	383,264	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	204,554	2,205	12,897	94,721	314,377	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,575,948	312,765	107,819	302,851	2,299,383	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,320,984	146,783	55,474	147,536	1,670,777	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,225,960	98,562	282,729	163,831	1,771,082	54.00
60.00	06000	LABORATORY	2,477,381	41,105	37,584	215,448	2,771,518	60.00
65.00	06500	RESPIRATORY THERAPY	576,566	89,186	26,297	133,242	825,291	65.00
66.00	06600	PHYSICAL THERAPY	1,168,782	175,944	19,564	300,077	1,664,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	273,510	13,813	0	71,774	359,097	67.00
69.00	06900	ELECTROCARDIOLOGY	130,342	84,470	18,074	33,308	266,194	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,001	0	1,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,505	0	0	0	65,505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,310,297	17,971	7,902	65,281	1,401,451	73.00
76.00	03550	BEHAVIORIAL HEALTH	267,058	36,779	947	41,605	346,389	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	2,083,288	164,726	17,390	489,449	2,754,853	88.00
88.01	08801	RHC - GIRARD	245,081	0	0	42,401	287,482	88.01
90.00	09000	CLINIC	343,552	71,243	1,890	74,630	491,315	90.00
91.00	09100	EMERGENCY	2,788,850	61,615	10,167	382,529	3,243,161	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	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)	30,445,174	2,203,362	788,832	3,483,113	30,425,751	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,107	19	0	5,126	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	58,335	0	0	0	58,335	194.00
194.01	07951	FUND DEVELOPMENT	45,535	1,702	297	12,298	59,832	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,549,044	2,210,171	789,148	3,495,411	30,549,044	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet B
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

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	6,047,553				5.00
7.00	00700	OPERATION OF PLANT	291,783	1,473,934			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,577	0	412,083		8.00
9.00	00900	HOUSEKEEPING	119,573	10,464	0	614,483	9.00
10.00	01000	DIETARY	123,580	40,286	0	16,072	680,617
11.00	01100	CAFETERIA	9,967	40,595	0	16,195	412,419
13.00	01300	NURSING ADMINISTRATION	105,381	17,506	0	6,984	0
14.00	01400	CENTRAL SERVICE & SUPPLY	122,568	23,201	0	9,256	0
16.00	01600	MEDICAL RECORDS & LIBRARY	94,599	10,829	0	4,320	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	77,596	2,216	0	884	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	567,543	314,440	193,861	125,441	268,198
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	412,388	147,567	34,258	58,871	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	437,146	99,089	37,853	39,531	0
60.00	06000	LABORATORY	684,077	41,324	0	16,486	0
65.00	06500	RESPIRATORY THERAPY	203,702	89,663	2,881	35,770	0
66.00	06600	PHYSICAL THERAPY	410,806	176,884	33,752	70,567	0
67.00	06700	OCCUPATIONAL THERAPY	88,634	13,887	0	5,540	0
69.00	06900	ELECTROCARDIOLOGY	65,703	84,921	0	33,879	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	247	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,168	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	345,912	18,067	0	7,208	0
76.00	03550	BEHAVIORIAL HEALTH	85,497	36,976	0	14,751	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	679,964	165,606	233	66,067	0
88.01	08801	RHC - GIRARD	70,957	0	0	30,644	0
90.00	09000	CLINIC	121,268	71,623	0	28,574	0
91.00	09100	EMERGENCY	800,486	61,945	109,245	24,712	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,017,122	1,467,089	412,083	611,752	680,617
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,265	5,134	0	2,048	0
194.00	07950	NONREIMBURSABLE COSTS CENTERS	14,398	0	0	0	0
194.01	07951	FUND DEVELOPMENT	14,768	1,711	0	683	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	6,047,553	1,473,934	412,083	614,483	680,617

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet B
Part I
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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	519,555					11.00
13.00	01300	NURSING ADMINISTRATION	12,348	569,168				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	9,182	0	660,788			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,364	0	0	520,376		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,101	17,363	0	0	419,537	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	94,666	232,040	0	23,273	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,344	76,865	0	35,567	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,951	419,537	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,104	0	0	142,830	0	54.00
60.00	06000	LABORATORY	64,814	0	0	116,457	0	60.00
65.00	06500	RESPIRATORY THERAPY	33,606	0	0	7,953	0	65.00
66.00	06600	PHYSICAL THERAPY	65,402	0	0	46,365	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,936	0	0	8,357	0	67.00
69.00	06900	ELECTROCARDIOLOGY	8,820	0	0	10,251	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	660,788	11,530	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	952	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,483	30,542	0	37,243	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	12,257	30,025	0	2,927	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0	0	0	22,006	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	2,296	0	88.01
90.00	09000	CLINIC	19,585	47,959	0	3,390	0	90.00
91.00	09100	EMERGENCY	62,643	134,374	0	42,028	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)	517,655	569,168	660,788	520,376	419,537	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	1,900	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)	519,555	569,168	660,788	520,376	419,537	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet B
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

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	4,118,845	0	4,118,845	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,467,637	0	2,467,637	50.00
53.00	05300	ANESTHESIOLOGY	426,488	0	426,488	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,570,635	0	2,570,635	54.00
60.00	06000	LABORATORY	3,694,676	0	3,694,676	60.00
65.00	06500	RESPIRATORY THERAPY	1,198,866	0	1,198,866	65.00
66.00	06600	PHYSICAL THERAPY	2,468,143	0	2,468,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	488,451	0	488,451	67.00
69.00	06900	ELECTROCARDIOLOGY	469,768	0	469,768	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	673,566	0	673,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,625	0	82,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,852,906	0	1,852,906	73.00
76.00	03550	BEHAVIORIAL HEALTH	528,822	0	528,822	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	3,688,729	0	3,688,729	88.00
88.01	08801	RHC - GIRARD	391,379	0	391,379	88.01
90.00	09000	CLINIC	783,714	0	783,714	90.00
91.00	09100	EMERGENCY	4,478,594	0	4,478,594	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)	30,383,844	0	30,383,844	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	13,573	0	13,573	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	72,733	0	72,733	194.00
194.01	07951	FUND DEVELOPMENT	78,894	0	78,894	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)	30,549,044	0	30,549,044	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet B
Part II
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,018	747	4,765	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,596	485,388	172,776	703,760	5.00
7.00	00700	OPERATION OF PLANT	0	254,666	4,298	258,964	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	10,409	882	11,291	9.00
10.00	01000	DIETARY	5,161	40,072	6,759	51,992	10.00
11.00	01100	CAFETERIA	0	40,379	0	40,379	11.00
13.00	01300	NURSING ADMINISTRATION	5,862	17,413	630	23,905	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	23,078	0	23,078	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,772	3,005	13,777	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,205	12,897	15,102	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,309	312,765	107,819	434,893	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	548,460	146,783	55,474	750,717	50.00
53.00	05300	ANESTHESIOLOGY	4,400	0	0	4,400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,562	282,729	381,291	54.00
60.00	06000	LABORATORY	29,786	41,105	37,584	108,475	60.00
65.00	06500	RESPIRATORY THERAPY	18,075	89,186	26,297	133,558	65.00
66.00	06600	PHYSICAL THERAPY	0	175,944	19,564	195,508	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,813	0	13,813	67.00
69.00	06900	ELECTROCARDIOLOGY	0	84,470	18,074	102,544	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,001	1,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,147	17,971	7,902	114,020	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	36,779	947	37,726	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	164,726	17,390	182,116	88.00
88.01	08801	RHC - GIRARD	25,638	0	0	25,638	88.01
90.00	09000	CLINIC	0	71,243	1,890	73,133	90.00
91.00	09100	EMERGENCY	2,155	61,615	10,167	73,937	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)	787,589	2,203,362	788,832	3,779,783	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,107	19	5,126	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	1,702	297	1,999	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)	787,589	2,210,171	789,148	3,786,908	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	704,457					5.00
7.00	00700	OPERATION OF PLANT	33,989	293,073				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,503	0	9,503			8.00
9.00	00900	HOUSEKEEPING	13,929	2,081	0	27,424		9.00
10.00	01000	DIETARY	14,396	8,010	0	717	75,192	10.00
11.00	01100	CAFETERIA	1,161	8,072	0	723	45,562	11.00
13.00	01300	NURSING ADMINISTRATION	12,276	3,481	0	312	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	14,278	4,613	0	413	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,020	2,153	0	193	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	9,039	441	0	39	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	66,112	62,522	4,472	5,600	29,630	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,038	29,342	790	2,627	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,922	19,703	873	1,764	0	54.00
60.00	06000	LABORATORY	79,687	8,217	0	736	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,729	17,828	66	1,596	0	65.00
66.00	06600	PHYSICAL THERAPY	47,854	35,171	778	3,149	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,325	2,761	0	247	0	67.00
69.00	06900	ELECTROCARDIOLOGY	7,654	16,886	0	1,512	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,883	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,295	3,592	0	322	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	9,959	7,352	0	658	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	79,208	32,929	5	2,949	0	88.00
88.01	08801	RHC - GIRARD	8,266	0	0	1,368	0	88.01
90.00	09000	CLINIC	14,126	14,241	0	1,275	0	90.00
91.00	09100	EMERGENCY	93,235	12,317	2,519	1,103	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	700,913	291,712	9,503	27,303	75,192	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	147	1,021	0	91	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	1,677	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	1,720	340	0	30	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	704,457	293,073	9,503	27,424	75,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet B
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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	95,897					11.00
13.00	01300 NURSING ADMINISTRATION	2,279	42,364				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	1,695	0	44,116			14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	5,051	0	0	32,287		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	1,311	1,292	0	0	27,353	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	17,472	17,271	0	1,445		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,785	5,721	0	2,209		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	432		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,956	0	0	8,841		54.00
60.00	06000 LABORATORY	11,963	0	0	7,231		60.00
65.00	06500 RESPIRATORY THERAPY	6,203	0	0	494		65.00
66.00	06600 PHYSICAL THERAPY	12,072	0	0	2,879		66.00
67.00	06700 OCCUPATIONAL THERAPY	2,388	0	0	519		67.00
69.00	06900 ELECTROCARDIOLOGY	1,628	0	0	637		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	44,116	716		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,304	2,273	0	2,313		73.00
76.00	03550 BEHAVIORIAL HEALTH	2,262	2,235	0	182		76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	0	0	0	1,366		88.00
88.01	08801 RHC - GIRARD	0	0	0	143		88.01
90.00	09000 CLINIC	3,615	3,570	0	211		90.00
91.00	09100 EMERGENCY	11,562	10,002	0	2,610		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)	95,546	42,364	44,116	32,287	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	351	0	0	0		194.01
200.00	Cross Foot Adjustments					27,353	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	95,897	42,364	44,116	32,287	27,353	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet B
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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	639,830	0	639,830	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	845,430	0	845,430	50.00
53.00	05300	ANESTHESIOLOGY	4,832	0	4,832	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	471,573	0	471,573	54.00
60.00	06000	LABORATORY	216,603	0	216,603	60.00
65.00	06500	RESPIRATORY THERAPY	183,656	0	183,656	65.00
66.00	06600	PHYSICAL THERAPY	297,820	0	297,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,151	0	30,151	67.00
69.00	06900	ELECTROCARDIOLOGY	130,906	0	130,906	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,862	0	45,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,942	0	1,942	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165,208	0	165,208	73.00
76.00	03550	BEHAVIORIAL HEALTH	60,431	0	60,431	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	299,240	0	299,240	88.00
88.01	08801	RHC - GIRARD	35,473	0	35,473	88.01
90.00	09000	CLINIC	110,273	0	110,273	90.00
91.00	09100	EMERGENCY	207,806	0	207,806	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)	3,747,036	0	3,747,036	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,385	0	6,385	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	1,677	0	1,677	194.00
194.01	07951	FUND DEVELOPMENT	4,457	0	4,457	194.01
200.00		Cross Foot Adjustments	27,353	0	27,353	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,786,908	0	3,786,908	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet B-1

Date/Time Prepared:
12/17/2021 7:00 pm

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		746,518				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144	707	12,942,776			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,394	163,443	1,895,643	-6,047,553	24,501,491	5.00
7.00	00700	OPERATION OF PLANT	9,126	4,066	325,784	0	1,182,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	330,506	8.00
9.00	00900	HOUSEKEEPING	373	834	334,201	0	484,446	9.00
10.00	01000	DIETARY	1,436	6,394	208,231	0	500,679	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	40,379	11.00
13.00	01300	NURSING ADMINISTRATION	624	596	300,941	0	426,949	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	827	0	106,117	0	496,581	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386	2,843	252,077	0	383,264	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	12,200	350,730	0	314,377	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,208	101,995	1,121,391	0	2,299,383	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,260	52,477	546,293	0	1,670,777	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	267,454	606,630	0	1,771,082	54.00
60.00	06000	LABORATORY	1,473	35,554	797,758	0	2,771,518	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	24,876	493,366	0	825,291	65.00
66.00	06600	PHYSICAL THERAPY	6,305	18,507	1,111,122	0	1,664,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	265,763	0	359,097	67.00
69.00	06900	ELECTROCARDIOLOGY	3,027	17,098	123,332	0	266,194	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	947	0	0	1,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	65,505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	7,475	241,721	0	1,401,451	73.00
76.00	03550	BEHAVIORIAL HEALTH	1,318	896	154,056	0	346,389	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	5,903	16,451	1,812,324	0	2,754,853	88.00
88.01	08801	RHC - GIRARD	0	0	157,000	0	287,482	88.01
90.00	09000	CLINIC	2,553	1,788	276,340	0	491,315	90.00
91.00	09100	EMERGENCY	2,208	9,618	1,416,421	0	3,243,161	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)	78,958	746,219	12,897,241	-6,047,553	24,378,198	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	5,126	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	58,335	194.00
194.01	07951	FUND DEVELOPMENT	61	281	45,535	0	59,832	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)	2,210,171	789,148	3,495,411		6,047,553	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.905495	1.057105	0.270067		0.246824	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,765		704,457	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000368		0.028752	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 08/01/2020
To 07/31/2021

Worksheet B-1

Date/Time Prepared:
12/17/2021 7:00 pm

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	52,538				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	118,293			8.00
9.00	00900	HOUSEKEEPING	373	0	54,903		9.00
10.00	01000	DIETARY	1,436	0	1,436	30,161	10.00
11.00	01100	CAFETERIA	1,447	0	1,447	18,276	11.00
13.00	01300	NURSING ADMINISTRATION	624	0	624	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	827	0	827	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386	0	386	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,208	55,650	11,208	11,885	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,260	9,834	5,260	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	10,866	3,532	0	54.00
60.00	06000	LABORATORY	1,473	0	1,473	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	827	3,196	0	65.00
66.00	06600	PHYSICAL THERAPY	6,305	9,689	6,305	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	495	0	67.00
69.00	06900	ELECTROCARDIOLOGY	3,027	0	3,027	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	0	644	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	1,318	0	1,318	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	5,903	67	5,903	0	88.00
88.01	08801	RHC - GIRARD	0	0	2,738	0	88.01
90.00	09000	CLINIC	2,553	0	2,553	0	90.00
91.00	09100	EMERGENCY	2,208	31,360	2,208	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				1,385	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,294	118,293	54,659	30,161	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	0	183	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	0	61	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,473,934	412,083	614,483	680,617	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.054627	3.483579	11.192157	22.566128	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	293,073	9,503	27,424	75,192	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.578305	0.080334	0.499499	2.493021	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 08/01/2020
To 07/31/2021

Worksheet B-1

Date/Time Prepared:
12/17/2021 7:00 pm

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	106,799				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	100			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	62,499,656		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,258	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	43,540	0	2,795,163	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,423	0	4,271,769	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	834,841	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	17,154,392	0	54.00
60.00	06000	LABORATORY	0	0	13,987,156	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	955,153	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	5,568,651	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,003,772	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,231,158	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	1,384,769	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	114,390	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,731	0	4,473,066	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	5,634	0	351,592	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	2,643,039	0	88.00
88.01	08801	RHC - GIRARD	0	0	275,730	0	88.01
90.00	09000	CLINIC	8,999	0	407,164	0	90.00
91.00	09100	EMERGENCY	25,214	0	5,047,851	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		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,799	100	62,499,656	100	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	0	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)	569,168	660,788	520,376	419,537	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.329338	6,607.880000	0.008326	4,195.370000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,364	44,116	32,287	27,353	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.396670	441.160000	0.000517	273.530000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet C
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,118,845		4,118,845	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,467,637		2,467,637	0	0	50.00
53.00	05300	ANESTHESIOLOGY	426,488		426,488	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,570,635		2,570,635	0	0	54.00
60.00	06000	LABORATORY	3,694,676		3,694,676	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,198,866	0	1,198,866	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,468,143	0	2,468,143	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	488,451	0	488,451	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	469,768		469,768	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	673,566		673,566	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,625		82,625	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,852,906		1,852,906	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	528,822		528,822	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	3,688,729		3,688,729	0	0	88.00
88.01	08801	RHC - GIRARD	391,379		391,379	0	0	88.01
90.00	09000	CLINIC	783,714		783,714	0	0	90.00
91.00	09100	EMERGENCY	4,478,594		4,478,594	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	605,780		605,780	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)	30,989,624	0	30,989,624	0	0	200.00
201.00		Less Observation Beds	605,780		605,780			201.00
202.00		Total (see instructions)	30,383,844	0	30,383,844	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet C
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,988,473		1,988,473			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	139,796	4,131,973	4,271,769	0.577662	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	34,914	799,927	834,841	0.510861	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	822,701	16,331,691	17,154,392	0.149853	0.000000	54.00
60.00	06000	LABORATORY	1,230,147	12,757,009	13,987,156	0.264148	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	212,645	742,508	955,153	1.255156	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	607,856	4,960,795	5,568,651	0.443221	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	397,040	606,732	1,003,772	0.486615	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	38,452	1,192,706	1,231,158	0.381566	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	563,855	820,914	1,384,769	0.486410	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	114,390	114,390	0.722310	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,695,167	2,777,899	4,473,066	0.414236	0.000000	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	351,592	351,592	1.504079	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	2,643,039	2,643,039			88.00
88.01	08801	RHC - GIRARD	2,868	272,862	275,730			88.01
90.00	09000	CLINIC	13,470	393,694	407,164	1.924812	0.000000	90.00
91.00	09100	EMERGENCY	143,890	4,903,961	5,047,851	0.887228	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	56,505	750,185	806,690	0.750945	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)	7,947,779	54,551,877	62,499,656			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,947,779	54,551,877	62,499,656			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet C
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

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 08/01/2020
To 07/31/2021Worksheet D
Part II
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	845,430	4,271,769	0.197911	66,383	13,138	50.00
53.00	05300 ANESTHESIOLOGY	4,832	834,841	0.005788	21,817	126	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	471,573	17,154,392	0.027490	461,027	12,674	54.00
60.00	06000 LABORATORY	216,603	13,987,156	0.015486	510,688	7,909	60.00
65.00	06500 RESPIRATORY THERAPY	183,656	955,153	0.192279	72,196	13,882	65.00
66.00	06600 PHYSICAL THERAPY	297,820	5,568,651	0.053482	63,086	3,374	66.00
67.00	06700 OCCUPATIONAL THERAPY	30,151	1,003,772	0.030038	34,580	1,039	67.00
69.00	06900 ELECTROCARDIOLOGY	130,906	1,231,158	0.106328	24,180	2,571	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45,862	1,384,769	0.033119	205,840	6,817	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,942	114,390	0.016977	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	165,208	4,473,066	0.036934	541,602	20,004	73.00
76.00	03550 BEHAVIORIAL HEALTH	60,431	351,592	0.171878	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	299,240	2,643,039	0.113218	0	0	88.00
88.01	08801 RHC - GIRARD	35,473	275,730	0.128651	0	0	88.01
90.00	09000 CLINIC	110,273	407,164	0.270832	8,520	2,307	90.00
91.00	09100 EMERGENCY	207,806	5,047,851	0.041167	19,018	783	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	94,103	806,690	0.116653	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	3,201,309	60,511,183		2,028,937	84,624	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet D
Part IV
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	419,537	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	419,537	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet D
Part IV
Date/Time Prepared:
12/17/2021 7:00 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,271,769	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	419,537	0	834,841	0.502535	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,154,392	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,987,156	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	955,153	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,568,651	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,003,772	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,231,158	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,384,769	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	114,390	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,473,066	0.000000	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	0	351,592	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0	0	0	2,643,039	0.000000	88.00
88.01	08801	RHC - GIRARD	0	0	0	275,730	0.000000	88.01
90.00	09000	CLINIC	0	0	0	407,164	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,047,851	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	806,690	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	419,537	0	60,511,183		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet D
Part IV
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	66,383	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	21,817	10,964	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	461,027	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	510,688	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	72,196	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	63,086	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	34,580	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	24,180	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	205,840	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	541,602	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	8,520	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	19,018	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,028,937	10,964	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet D
Part V
Date/Time Prepared:
12/17/2021 7:00 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.577662	0	1,519,630	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.510861	0	315,979	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149853	0	6,275,032	0	0	54.00
60.00	06000	LABORATORY	0.264148	0	4,480,994	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.255156	0	321,937	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.443221	0	1,618,592	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.486615	0	151,448	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.381566	0	538,535	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486410	0	265,749	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.722310	0	109,824	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414236	0	1,475,099	3,135	0	73.00
76.00	03550	BEHAVORIAL HEALTH	1.504079	0	349,488	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	1.924812	0	116,984	0	0	90.00
91.00	09100	EMERGENCY	0.887228	0	1,739,315	235	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.750945	0	377,691	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	19,656,297	3,370	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	19,656,297	3,370	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021Worksheet D
Part V
Date/Time Prepared:
12/17/2021 7:00 pm

			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	877,833	0		50.00
53.00	05300	ANESTHESIOLOGY	161,421	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	940,332	0		54.00
60.00	06000	LABORATORY	1,183,646	0		60.00
65.00	06500	RESPIRATORY THERAPY	404,081	0		65.00
66.00	06600	PHYSICAL THERAPY	717,394	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	73,697	0		67.00
69.00	06900	ELECTROCARDIOLOGY	205,487	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,263	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,327	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	611,039	1,299		73.00
76.00	03550	BEHAVORIAL HEALTH	525,658	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	225,172	0		90.00
91.00	09100	EMERGENCY	1,543,169	208		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	283,625	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,961,144	1,507		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,961,144	1,507		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347
Component CCN: 14-Z347

Period:
From 08/01/2020
To 07/31/2021

Worksheet D
Part IV
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Title XVIII		Swing Beds - SNF		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	419,537	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC - CARLINVILLE	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	419,537	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347
Component CCN: 14-Z347

Period:
From 08/01/2020
To 07/31/2021

Worksheet D
Part IV
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,271,769	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	419,537	0	834,841	0.502535	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,154,392	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,987,156	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	955,153	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,568,651	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,003,772	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,231,158	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,384,769	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	114,390	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,473,066	0.000000	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	0	351,592	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0	0	0	2,643,039	0.000000	88.00
88.01	08801	RHC - GIRARD	0	0	0	275,730	0.000000	88.01
90.00	09000	CLINIC	0	0	0	407,164	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,047,851	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	806,690	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	419,537	0	60,511,183		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1347

Period:

From 08/01/2020

To 07/31/2021

Worksheet D

Part IV

Date/Time Prepared:

12/17/2021 7:00 pm

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)	Cost
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	1,976	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	158,691	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	306,370	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	69,127	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	387,686	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	259,851	0	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	2,480	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	184,562	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	586,787	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	4,917	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	9,416	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		1,971,863	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 08/01/2020
To 07/31/2021Part V
Date/Time Prepared:
12/17/2021 7:00 pm

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.577662	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.510861	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.149853	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.264148	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	1.255156	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.443221	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.486615	0	0	0	0	67.00	
69.00	06900	ELECTROCARDIOLOGY	0.381566	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486410	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.722310	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414236	0	0	0	0	73.00	
76.00	03550	BEHAVORIAL HEALTH	1.504079	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	1.924812	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.887228	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.750945	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 08/01/2020
To 07/31/2021Part V
Date/Time Prepared:
12/17/2021 7:00 pm

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03550	BEHAVIORIAL 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 08/01/2020 To 07/31/2021	Worksheet D-1 Date/Time Prepared: 12/17/2021 7:00 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,015 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,549 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,116 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			624 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)			761 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			12 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)			69 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			684 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)			509 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)			601 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			169.82 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			174.91 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,118,845 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)			2,038 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)			12,069 25.00
26.00	Total swing-bed cost (see instructions)			1,951,750 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,167,095 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)			2,167,095 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)			1,399.02 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			956,930 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)			956,930 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet D-1

Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					755,852	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,712,782	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)					712,101	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					840,811	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,552,912	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)					433	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,399.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					605,780	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet D-1

Date/Time Prepared:
12/17/2021 7:00 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	639,830	4,118,845	0.155342	605,780	94,103
91.00	Nursing School cost	0	4,118,845	0.000000	605,780	0
92.00	Allied health cost	0	4,118,845	0.000000	605,780	0
93.00	All other Medical Education	0	4,118,845	0.000000	605,780	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1347	Period: From 08/01/2020 To 07/31/2021	Worksheet D-3 Date/Time Prepared: 12/17/2021 7:00 pm	
Cost Center Description		Title XVIII	Hospital	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		724,782		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.577662	66,383	38,347	50.00
53.00	05300 ANESTHESIOLOGY	0.510861	21,817	11,145	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.149853	461,027	69,086	54.00
60.00	06000 LABORATORY	0.264148	510,688	134,897	60.00
65.00	06500 RESPIRATORY THERAPY	1.255156	72,196	90,617	65.00
66.00	06600 PHYSICAL THERAPY	0.443221	63,086	27,961	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.486615	34,580	16,827	67.00
69.00	06900 ELECTROCARDIOLOGY	0.381566	24,180	9,226	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486410	205,840	100,123	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.722310	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.414236	541,602	224,351	73.00
76.00	03550 BEHAVIORIAL HEALTH	1.504079	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	1.924812	8,520	16,399	90.00
91.00	09100 EMERGENCY	0.887228	19,018	16,873	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.750945	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)		2,028,937	755,852	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,028,937		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1347 Component CCN: 14-Z347	Period: From 08/01/2020 To 07/31/2021	Worksheet D-3 Date/Time Prepared: 12/17/2021 7:00 pm	
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				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.577662	1,976	1,141	50.00
53.00	05300 ANESTHESIOLOGY	0.510861	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.149853	158,691	23,780	54.00
60.00	06000 LABORATORY	0.264148	306,370	80,927	60.00
65.00	06500 RESPIRATORY THERAPY	1.255156	69,127	86,765	65.00
66.00	06600 PHYSICAL THERAPY	0.443221	387,686	171,831	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.486615	259,851	126,447	67.00
69.00	06900 ELECTROCARDIOLOGY	0.381566	2,480	946	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486410	184,562	89,773	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.722310	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.414236	586,787	243,068	73.00
76.00	03550 BEHAVIORIAL HEALTH	1.504079	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	1.924812	4,917	9,464	90.00
91.00	09100 EMERGENCY	0.887228	9,416	8,354	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.750945	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)		1,971,863	842,496	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)		1,971,863		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1347	Period: From 08/01/2020 To 07/31/2021	Worksheet E Part B Date/Time Prepared: 12/17/2021 7:00 pm
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,962,651	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)		7,962,651	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)		8,042,278	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)		41,621	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,896,653	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)		5,104,004	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)		5,104,004	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,104,004	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)		310,795	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		202,017	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		309,627	36.00
37.00	Subtotal (see instructions)		5,306,021	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,306,021	40.00
40.01	Sequestration adjustment (see instructions)		0	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		6,082,920	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-776,899	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	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 08/01/2020
To 07/31/2021Worksheet E-1
Part I
Date/Time Prepared:
12/17/2021 7:00 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,637,822		5,990,278	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	02/18/2021	92,642	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		92,642	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)		1,637,822		6,082,920	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		98,972		776,899	6.02	
7.00	Total Medicare program liability (see instructions)		1,538,850		5,306,021	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 08/01/2020
To 07/31/2021Part I
Date/Time Prepared:
12/17/2021 7:00 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,247,120		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,247,120		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		137,671		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,384,791		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1347	Period: From 08/01/2020 To 07/31/2021	Worksheet E-1 Part II Date/Time Prepared: 12/17/2021 7:00 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1347

Period:

Worksheet E-2

Component CCN: 14-Z347

From 08/01/2020

Date/Time Prepared:

To 07/31/2021

12/17/2021 7:00 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,568,441	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)		850,921	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		1,110	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)		2,419,362	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,419,362	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)		2,419,362	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		34,571	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,384,791	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)		2,384,791	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		2,247,120	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, 19.02, 19.25, 20, and 21)		137,671	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 08/01/2020 To 07/31/2021	Worksheet E-3 Part V Date/Time Prepared: 12/17/2021 7:00 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,712,782	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)		1,712,782	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,729,910	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)		1,729,910	19.00
20.00	Deductibles (exclude professional component)		210,201	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,519,709	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,519,709	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		29,447	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		19,141	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,039	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,538,850	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)		1,538,850	30.00
30.01	Sequestration adjustment (see instructions)		0	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		1,637,822	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)		-98,972	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 08/01/2020
To 07/31/2021

Worksheet G

Date/Time Prepared:
12/17/2021 7:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	16,206,218	0	0	0	1.00
2.00	Temporary investments	694,110	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,855,888	0	0	0	4.00
5.00	Other receivable	217,231	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-991,000	0	0	0	6.00
7.00	Inventory	295,512	0	0	0	7.00
8.00	Prepaid expenses	198,955	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,476,914	0	0	0	11.00
FIXED ASSETS						
12.00	Land	500,172	0	0	0	12.00
13.00	Land improvements	2,524,060	0	0	0	13.00
14.00	Accumulated depreciation	-1,259,600	0	0	0	14.00
15.00	Buildings	26,258,922	0	0	0	15.00
16.00	Accumulated depreciation	-14,372,827	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,801,153	0	0	0	23.00
24.00	Accumulated depreciation	-7,538,428	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,180,327	0	0	0	27.00
28.00	Accumulated depreciation	-938,967	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,154,812	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,710,942	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,710,942	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,342,668	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,310,338	0	0	0	37.00
38.00	Salaries, wages, and fees payable	730,670	0	0	0	38.00
39.00	Payroll taxes payable	41,574	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,055,297	0	0	0	40.00
41.00	Deferred income	29,433	0	0	0	41.00
42.00	Accelerated payments	5,769,163	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	250,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,186,475	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,852,843	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,852,843	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	23,039,318	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	23,303,350				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	23,303,350	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,342,668	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet G-1

Date/Time Prepared:
12/17/2021 7:00 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,844,896		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,334,562				2.00
3.00	Total (sum of line 1 and line 2)		23,179,458		0		3.00
4.00	CHANGE IN BENEFICIAL INT IN PERP TR	123,892		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)		123,892		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,303,350		0		11.00
12.00	DECREASE IN PERM RESTRICTED	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,303,350		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	CHANGE IN BENEFICIAL INT IN PERP TR		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 08/01/2020
To 07/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
12/17/2021 7:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,190,604		2,190,604	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	784,845		784,845	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)	2,975,449		2,975,449	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)	2,975,449		2,975,449	17.00
18.00	Ancillary services	5,651,655	0	5,651,655	18.00
19.00	Outpatient services	0	55,235,850	55,235,850	19.00
20.00	RHC - CARLINVILLE	0	2,643,039	2,643,039	20.00
20.01	RHC - GIRARD	0	275,730	275,730	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)	8,627,104	58,154,619	66,781,723	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,075,525		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)		33,075,525		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2020
To 07/31/2021

Worksheet G-3

Date/Time Prepared:
12/17/2021 7:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,781,723	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,487,063	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,294,660	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,075,525	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-780,865	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	19,711	6.00
7.00	Income from investments	671,979	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	8,423	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	81,429	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	222,719	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	13,312	24.01
24.02	BUSINESS INTERRUPTION PROCEEDS	222,514	24.02
24.03	OTHER	146,405	24.03
24.04	340B REVENUE	411,560	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	0	24.05
24.06	GRANTS	94,923	24.06
24.50	COVID-19 PHE Funding	6,222,452	24.50
25.00	Total other income (sum of lines 6-24)	8,115,427	25.00
26.00	Total (line 5 plus line 25)	7,334,562	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)	7,334,562	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8530

From 08/01/2020
To 07/31/2021Date/Time Prepared:
12/17/2021 7:00 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	945,755	0	945,755	0	945,755
2.00	Physician Assistant	91,970	0	91,970	0	91,970
3.00	Nurse Practitioner	181,970	0	181,970	0	181,970
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	11,513	0	11,513	0	11,513
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	791,079	0	791,079	-220,685	570,394
10.00	Subtotal (sum of lines 1 through 9)	2,022,287	0	2,022,287	-220,685	1,801,602
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	102,729	102,729	0	102,729
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	70,241	70,241	0	70,241
19.00	Other Health Care Costs	0	68,659	68,659	29,335	97,994
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	241,629	241,629	29,335	270,964
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,022,287	241,629	2,263,916	-191,350	2,072,566
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	10,722	0	10,722	0	10,722
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	10,722	0	10,722	0	10,722
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	0	0	0	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,033,009	241,629	2,274,638	-191,350	2,083,288

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8530

From 08/01/2020
To 07/31/2021Date/Time Prepared:
12/17/2021 7:00 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	945,755	1.00
2.00	Physician Assistant	0	91,970	2.00
3.00	Nurse Practitioner	0	181,970	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	11,513	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	570,394	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,801,602	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	102,729	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	70,241	18.00
19.00	Other Health Care Costs	0	97,994	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	270,964	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,072,566	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	10,722	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	10,722	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	2,083,288	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8532

From 08/01/2020
To 07/31/2021Date/Time Prepared:
12/17/2021 7:00 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	28,255	0	28,255	0	28,255
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	100,149	0	100,149	0	100,149
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	60,102	0	60,102	-31,600	28,502
10.00	Subtotal (sum of lines 1 through 9)	188,506	0	188,506	-31,600	156,906
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	37,993	37,993	0	37,993
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	16,734	16,734	0	16,734
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	54,727	54,727	0	54,727
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	188,506	54,727	243,233	-31,600	211,633
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	94	0	94	0	94
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	94	0	94	0	94
FACILITY OVERHEAD						
29.00	Facility Costs	0	33,354	33,354	0	33,354
30.00	Administrative Costs	0	0	0	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	33,354	33,354	0	33,354
32.00	Total facility costs (sum of lines 22, 28 and 31)	188,600	88,081	276,681	-31,600	245,081

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347

Period:

Worksheet M-1

Component CCN: 14-8532

From 08/01/2020
To 07/31/2021Date/Time Prepared:
12/17/2021 7:00 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	28,255		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	100,149		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	28,502		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	156,906		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	37,993		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	16,734		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	54,727		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	211,633		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	94		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	94		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	33,354		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	33,354		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	245,081		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347

Period:

Worksheet M-2

Component CCN: 14-8530

From 08/01/2020
To 07/31/2021Date/Time Prepared:
12/17/2021 7:00 pm

				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	3.01	8,596	2,688	8,091		1.00
2.00	Physician Assistant	0.53	678	1,344	712		2.00
3.00	Nurse Practitioner	1.40	3,442	1,344	1,882		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.94	12,716		10,685	12,716	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	0.11	59			59	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)	5.05	12,775			12,775	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)					2,072,566	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					10,722	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,083,288	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.994853	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)					1,605,441	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,605,441	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,605,441	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,597,178	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,669,744	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347

Period:

Worksheet M-2

Component CCN: 14-8532

From 08/01/2020
To 07/31/2021Date/Time Prepared:
12/17/2021 7:00 pm

		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	0.09	263	2,604	234
2.00	Physician Assistant	0.00	0	1,302	0
3.00	Nurse Practitioner	0.65	1,064	1,302	846
4.00	Subtotal (sum of lines 1 through 3)	0.74	1,327	1,080	1,327
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.74	1,327		1,327
9.00	Physician Services Under Agreements		0		0
					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)				211,633
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				94
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				211,727
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.999556
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				33,354
15.00	Parent provider overhead allocated to facility (see instructions)				146,298
16.00	Total overhead (sum of lines 14 and 15)				179,652
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				179,652
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				179,572
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				391,205

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2020 To 07/31/2021	Worksheet M-3 Date/Time Prepared: 12/17/2021 7:00 pm	
		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)			3,669,744	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			15,058	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,654,686	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,775	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)			12,775	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			286.08	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	287.45	8.00
9.00	Rate for Program covered visits (see instructions)	286.08	286.08	286.08	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,473	724	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	421,396	207,122	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	628,518		16.00
16.01	Total program charges (see instructions)(from contractor's records)		348,243		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		45,712		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		82,502		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.)		414,759		16.04
16.05	Total program cost (see instructions)	0	497,261		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		27,567		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		54,993		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		497,261		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		14,985		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		512,246		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)		512,246		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		470,473		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)		41,773		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 08/01/2020 To 07/31/2021	Worksheet M-3 Date/Time Prepared: 12/17/2021 7:00 pm	
		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)			391,205	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			1,353	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			389,852	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,327	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)			1,327	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			293.78	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)	86.31	87.52	280.55	8.00
9.00	Rate for Program covered visits (see instructions)	293.78	293.78	280.55	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	166	106	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	48,767	29,738	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	78,505		16.00
16.01	Total program charges (see instructions)(from contractor's records)		40,307		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,036		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,913		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.)		52,998		16.04
16.05	Total program cost (see instructions)	0	58,911		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,344		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,185		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		58,911		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,353		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		60,264		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)		60,264		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		44,367		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)		15,897		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 VACCINE COST

 Provider CCN: 14-1347
 Component CCN: 14-8530

 Period:
 From 08/01/2020
 To 07/31/2021

 Worksheet M-4
 Date/Time Prepared:
 12/17/2021 7:00 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,801,602	1,801,602	1,801,602	1,801,602	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000055	0.000252	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	99	454	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,839	4,112	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,938	4,566	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,072,566	2,072,566	2,072,566	2,072,566	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,597,178	1,597,178	1,597,178	1,597,178	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001900	0.002203	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,035	3,519	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,973	8,085	0	0	10.00
11.00	Total number of injections/infusions (from your records)	24	111	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	290.54	72.84	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	24	110	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,973	8,012	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		15,058			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		14,985			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1347

Period:

Worksheet M-4

Component CCN: 14-8532

From 08/01/2020
To 07/31/2021Date/Time Prepared:
12/17/2021 7:00 pm

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	156,906	156,906	156,906	156,906	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000078	0.000131	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	12	21	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	608	91	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	620	112	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	211,633	211,633	211,633	211,633	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	179,572	179,572	179,572	179,572	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002930	0.000529	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	526	95	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,146	207	0	0	10.00
11.00	Total number of injections/infusions (from your records)	3	5	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	382.00	41.40	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	5	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,146	207	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		1,353			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1,353			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 08/01/2020 To 07/31/2021	Worksheet M-5 Date/Time Prepared: 12/17/2021 7:00 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		439,511	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		02/18/2021	30,962	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)		30,962	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		470,473	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		41,773	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		512,246	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 08/01/2020 To 07/31/2021	Worksheet M-5 Date/Time Prepared: 12/17/2021 7:00 pm	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			44,367	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			44,367	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			15,897	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			60,264	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00