This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141347	Period: From 08/01/2014 To 07/31/2015	Worksheet S Parts I-III Date/Time Prepared: 12/18/2015 10:12 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 12/18/2015 Time: 10:12 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARLINVILLE AREA HOSPITAL (141347) for the cost reporting period beginning 08/01/2014 and ending 07/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	14,429	28,047	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	-26,691	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RHC - CARLINVILLE I	0		11,041		0	10.00
10.01	RHC - GIRARD II	0		4,436		0	10.01
200.00	Total	0	-12,262	43,524	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: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2015 10:10 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 20733 NORTH BROAD STREET	PO Box:			1.00
2.00	City: CARLINVILLE	State: IL	Zip Code: 62626-	County: MACOUPIN	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	99914	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)	08/01/2014	07/31/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 12/18/2015 10:10 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2015 10:10 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 12/18/2015 10:10 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141347	Period: From 08/01/2014 To 07/31/2015	Worksheet S-2 Part I Date/Time Prepared: 12/18/2015 10:10 am

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	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	Y	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	163,365	0	0	118.01

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

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141347	Period: From 08/01/2014 To 07/31/2015	Worksheet S-2 Part I Date/Time Prepared: 12/18/2015 10:10 am

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	148,020	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	170.00

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 12/18/2015 10:10 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N			3.00
			Y/N	Type	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N			5.00
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N		11.00
					Y/N	
					1.00	
	Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N	14.00
	Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N	15.00
			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	11/20/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 12/18/2015 10:10 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				Y	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.				Y	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	BROWN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CARLINVILLE AREA HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-854-3141	MBROWN@CAHCARE.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 12/18/2015 10:10 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	11/20/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		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: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 12/18/2015 10:10 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	24,696.00	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	24,696.00	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	24,696.00	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						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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 12/18/2015 10:10 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	770	79	1,029			1.00
2.00	HMO and other (see instructions)	98	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	1,089	0	1,233			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	49			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,859	79	2,311			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)	1,859	79	2,311	0.00	124.26	14.00
15.00	CAH visits	10,775	2,973	20,846			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	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	1,140	489	3,310	0.00	6.29	26.00
26.01	RHC - GIRARD	325	452	1,311	0.00	3.64	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	134.19	27.00
28.00	Observation Bed Days		27	200			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 12/18/2015 10:10 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	238	25	316	1.00
2.00	HMO and other (see instructions)			27	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	238	25	316	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						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141347 Component CCN: 148530 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-8 | Date/Time Prepared: 12/18/2015 10:10 am

		Rural Health Clinic (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	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	16:00	07:30	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		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	16:00	07:30	16:00	07:30	16:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141347 Component CCN: 148530	Period: From 08/01/2014 To 07/31/2015	Worksheet S-8 Date/Time Prepared: 12/18/2015 10:10 am
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	16:00				11.00

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

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-8 Date/Time Prepared: 12/18/2015 10:10 am

		Rural Health Clinic (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	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award	Date	
			1.00	2.00	
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		MACOUPIN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141347 Component CCN: 148532	Period: From 08/01/2014 To 07/31/2015	Worksheet S-8 Date/Time Prepared: 12/18/2015 10:10 am
		Rural Health Clinic (RHC) II	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet S-10 | Date/Time Prepared: 12/18/2015 10:10 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.548628	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,297,806	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,267,127	5.00
6.00	Medicaid charges	7,033,049	6.00
7.00	Medicaid cost (line 1 times line 6)	3,858,528	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)	293,595	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	25,122	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	293,595	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	301,241	0	301,241	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	165,269	0	165,269	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	165,269	0	165,269	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	624,957	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	213,536	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	411,421	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	225,717	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	390,986	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	684,581	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,132,694	2,132,694	1,454,326	3,587,020	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		777,048	777,048	12,040	789,088	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,846,098	1,846,098	-1,547,802	298,296	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,202,447	2,338,865	3,541,312	230,258	3,771,570	5.00
7.00	00700	OPERATION OF PLANT	203,880	333,557	537,437	38,455	575,892	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,524	56,524	0	56,524	8.00
9.00	00900	HOUSEKEEPING	184,685	25,540	210,225	45,044	255,269	9.00
10.00	01000	DIETARY	144,804	189,296	334,100	42,012	376,112	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	359,709	15,708	375,417	57,288	432,705	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	169,732	62,890	232,622	44,975	277,597	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	180,331	4,422	184,753	18,686	203,439	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	859,374	127,878	987,252	187,960	1,175,212	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	153,184	277,335	430,519	40,701	471,220	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	437,758	678,228	1,115,986	108,903	1,224,889	54.00
60.00	06000	LABORATORY	546,237	570,538	1,116,775	141,732	1,258,507	60.00
65.00	06500	RESPIRATORY THERAPY	236,596	51,981	288,577	50,770	339,347	65.00
66.00	06600	PHYSICAL THERAPY	515,383	41,767	557,150	84,956	642,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,475	3,274	142,749	26,091	168,840	67.00
69.00	06900	ELECTROCARDIOLOGY	63,013	41,302	104,315	11,894	116,209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,641	111,960	186,601	21,270	207,871	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,613	32,613	0	32,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	198,709	663,500	862,209	30,046	892,255	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	550,444	121,551	671,995	108,873	780,868	88.00
88.01	08801	RHC - GIRARD	181,067	51,917	232,984	27,503	260,487	88.01
90.00	09000	CLINIC	160,627	213,269	373,896	29,080	402,976	90.00
91.00	09100	EMERGENCY	674,818	1,561,106	2,235,924	134,502	2,370,426	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		1,412,983	1,412,983	-1,412,983	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,236,914	13,743,844	20,980,758	-13,420	20,967,338	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	1,751	1,751	194.00
194.01	07951	FUND DEVELOPMENT	10,336	2,332	12,668	11,669	24,337	194.01
200.00		TOTAL (SUM OF LINES 118-199)	7,247,250	13,746,176	20,993,426	0	20,993,426	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-890,485	2,696,535		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-245,921	543,167		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	298,296		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-194,067	3,577,503		5.00
7.00	00700	OPERATION OF PLANT	-75	575,817		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,524		8.00
9.00	00900	HOUSEKEEPING	0	255,269		9.00
10.00	01000	DIETARY	-61,902	314,210		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	432,705		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,004	276,593		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	203,439		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,175,212		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,990	469,230		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-14,816	1,210,073		54.00
60.00	06000	LABORATORY	-300	1,258,207		60.00
65.00	06500	RESPIRATORY THERAPY	-30,168	309,179		65.00
66.00	06600	PHYSICAL THERAPY	-1,625	640,481		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	168,840		67.00
69.00	06900	ELECTROCARDIOLOGY	-31,790	84,419		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	207,871		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,613		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-30,635	861,620		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	780,868		88.00
88.01	08801	RHC - GIRARD	0	260,487		88.01
90.00	09000	CLINIC	-23,693	379,283		90.00
91.00	09100	EMERGENCY	-1,150,080	1,220,346		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 1-117)	-2,678,551	18,288,787		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	1,751		194.00
194.01	07951	FUND DEVELOPMENT	0	24,337		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,678,551	18,314,875		200.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-6 | Date/Time Prepared: 12/18/2015 10:10 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASSIFY RECRUITMENT EXPENSES					
1.00	RHC - CARLINVILLE	88.00	0	23,343		1.00
	TOTALS		0	23,343		
	B - RECLASS NONREIMBURSEABLE COSTS					
1.00	NONREIMBURSABLE COSTS CENTERS	194.00	0	1,751		1.00
	TOTALS		0	1,751		
	C - INSURANCE EXPENSE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	60,652		1.00
	TOTALS		0	60,652		
	E - INTEREST EXPENSE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,518		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,407,465		2.00
	TOTALS		0	1,412,983		
	H - DIRECTLY ASSIGN FICA					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,693		1.00
2.00	OPERATION OF PLANT	7.00	0	14,892		2.00
3.00	HOUSEKEEPING	9.00	0	13,626		3.00
4.00	DIETARY	10.00	0	10,594		4.00
5.00	NURSING ADMINISTRATION	13.00	0	25,870		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	13,557		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	62,289		7.00
8.00	OPERATING ROOM	50.00	0	9,283		8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	10,832		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,695		10.00
11.00	LABORATORY	60.00	0	39,624		11.00
12.00	RESPIRATORY THERAPY	65.00	0	19,352		12.00
13.00	PHYSICAL THERAPY	66.00	0	37,829		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	10,382		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	4,040		15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,561		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,337		17.00
18.00	RHC - CARLINVILLE	88.00	0	37,535		18.00
19.00	RHC - GIRARD	88.01	0	15,442		19.00
20.00	CLINIC	90.00	0	13,371		20.00
21.00	EMERGENCY	91.00	0	48,103		21.00
22.00	FUND DEVELOPMENT	194.01	0	3,815		22.00
	TOTALS		0	526,722		
	I - DIRECTLY ASSIGN HEALTH INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	180,653		1.00
2.00	OPERATION OF PLANT	7.00	0	23,563		2.00
3.00	HOUSEKEEPING	9.00	0	31,418		3.00
4.00	DIETARY	10.00	0	31,418		4.00
5.00	NURSING ADMINISTRATION	13.00	0	31,418		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	31,418		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	125,671		7.00
8.00	OPERATING ROOM	50.00	0	31,418		8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	7,854		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70,690		10.00
11.00	LABORATORY	60.00	0	102,108		11.00
12.00	RESPIRATORY THERAPY	65.00	0	31,418		12.00
13.00	PHYSICAL THERAPY	66.00	0	47,127		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	15,709		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	7,854		15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,709		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,709		17.00
18.00	RHC - CARLINVILLE	88.00	0	78,545		18.00
19.00	RHC - GIRARD	88.01	0	31,418		19.00
20.00	CLINIC	90.00	0	15,709		20.00
21.00	EMERGENCY	91.00	0	86,399		21.00
22.00	FUND DEVELOPMENT	194.01	0	7,854		22.00
	TOTALS		0	1,021,080		
	L - RECLASS RHC ADMIN SALARIES TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	49,907	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		49,907	0		
500.00	Grand Total: Increases		49,907	3,046,531		500.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-6 | Date/Time Prepared: 12/18/2015 10:10 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASSIFY RECRUITMENT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,343	0		1.00
	TOTALS		0	23,343			
	B - RECLASS NONREIMBURSEABLE COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,751	9		1.00
	TOTALS		0	1,751			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60,652	0		1.00
	TOTALS		0	60,652			
	E - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,412,983	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,412,983			
	H - DIRECTLY ASSIGN FICA						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	526,722	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
	TOTALS		0	526,722			
	I - DIRECTLY ASSIGN HEALTH INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,021,080	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
	TOTALS		0	1,021,080			
	L - RECLASS RHC ADMIN SALARIES TO ADMIN						
1.00	RHC - CARLINVILLE	88.00	30,550	0	0		1.00
2.00	RHC - GIRARD	88.01	19,357	0	0		2.00
	TOTALS		49,907	0			
500.00	Grand Total: Decreases		49,907	3,046,531			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-7 Part I Date/Time Prepared: 12/18/2015 10:10 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	517,172	0	0	0	0	1.00
2.00	Land Improvements	1,314,635	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,847,312	4,368,681	0	4,368,681	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	5,120,022	150,978	0	150,978	0	6.00
7.00	HIT designated Assets	1,188,306	0	0	0	7,979	7.00
8.00	Subtotal (sum of lines 1-7)	27,987,447	4,519,659	0	4,519,659	7,979	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,987,447	4,519,659	0	4,519,659	7,979	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	517,172	0	1.00
2.00	Land Improvements	1,314,635	0	2.00
3.00	Buildings and Fixtures	24,215,993	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	5,271,000	0	6.00
7.00	HIT designated Assets	1,180,327	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,499,127	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,499,127	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 12/18/2015 10:10 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,132,694	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	777,048	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,909,742	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	2,132,694		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	777,048		2.00
3.00	Total (sum of lines 1-2)	0	2,909,742		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 12/18/2015 10:10 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	26,047,800	0	26,047,800	0.801492	48,612	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,451,327	0	6,451,327	0.198508	12,040	2.00
3.00	Total (sum of lines 1-2)	32,499,127	0	32,499,127	1.000000	60,652	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	48,612	2,647,923	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	12,040	531,127	0	2.00
3.00	Total (sum of lines 1-2)	0	0	60,652	3,179,050	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	48,612	0	0	2,696,535	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	12,040	0	0	543,167	2.00
3.00	Total (sum of lines 1-2)	0	60,652	0	0	3,239,702	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-8 | Date/Time Prepared: 12/18/2015 10:10 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-29,246	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	-856	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	-2,063	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	-1,150,080			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	-59,745	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	-30,635	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,004	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-245,921	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-8 | Date/Time Prepared: 12/18/2015 10:10 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	DIETARY DISCOUNTS	B	-2,157	DIETARY	10.00	0	33.00
33.01	RADIOLOGY DISCOUNTS	B	-14,816	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	PT PROF FEES	B	-1,025	PHYSICAL THERAPY	66.00	0	33.02
33.03	PREVIOUS DEBT ISSUANCE COSTS	A	-855,203	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.03
33.04	CONTRACT LAB	B	-300	LABORATORY	60.00	0	33.04
33.05	SUPPLIES	B	-1,990	OPERATING ROOM	50.00	0	33.05
33.06	AHA & IHA DUES	A	-8,013	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PLANT OPERATION DISCOUNTS	B	-75	OPERATION OF PLANT	7.00	0	33.07
36.00	TELEVISION DEPRECIATION	A	-4,273	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00			0		0.00	0	37.00
39.00	MED STAFF RELATIONS	A	-11,852	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00	ADVERTISING	A	-163,329	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	TELEPHONE DEPRECIATION	A	-1,763	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-5,096	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-23,693	CLINIC	90.00	0	44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,430	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	INSURANCE PROCEEDS	A	-428	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05			0		0.00	0	44.05
44.06			0		0.00	0	44.06
44.07			0		0.00	0	44.07
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03			0		0.00	0	45.03
45.04	DAISY PROGRAM	B	-600	PHYSICAL THERAPY	66.00	0	45.04
45.05	EKG PROFESSIONAL FEES	A	-31,790	ELECTROCARDIOLOGY	69.00	0	45.05
45.06	SLEEP STUDY PROFESSONAL FEES	A	-30,168	RESPIRATORY THERAPY	65.00	0	45.06
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.09			0		0.00	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,678,551				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: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 12/18/2015 10:10 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,503,257	1,117,521	385,736	0	0	1.00
2.00	91.00	EMERGENCY	32,559	32,559	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,535,816	1,150,080	385,736		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	1,117,521		1.00
2.00	91.00	EMERGENCY	0	0	0	32,559		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,150,080		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/18/2015 10:10 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.57	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	302.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.45	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)	35.23	35.23	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			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)					21,329	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					21,329	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)					21,329	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)					70.45	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					54,951	22.00
23.00	Total salary equivalency (see instructions)					54,951	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/18/2015 10:10 am

Speech Pathology | Cost

						1.00	
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)	70.45	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)	54,951		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	54,951		63.00
64.00	Total cost of outside supplier services (from your records)	17,395		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B Part I Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,696,535	2,696,535				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	543,167		543,167			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	298,296	0	0	298,296		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,577,503	544,977	80,406	51,546	4,254,432	5.00
7.00	00700	OPERATION OF PLANT	575,817	376,688	18,581	8,392	979,478	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,524	0	0	0	56,524	8.00
9.00	00900	HOUSEKEEPING	255,269	17,623	20	7,602	280,514	9.00
10.00	01000	DIETARY	314,210	67,844	19,171	5,960	407,185	10.00
11.00	01100	CAFETERIA	0	68,364	0	0	68,364	11.00
13.00	01300	NURSING ADMINISTRATION	432,705	11,197	715	14,806	459,423	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	276,593	50,505	5,197	6,986	339,281	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	203,439	3,732	40	7,422	214,633	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,175,212	529,527	40,986	35,372	1,781,097	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	469,230	248,511	64,287	6,305	788,333	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,210,073	166,871	220,853	18,018	1,615,815	54.00
60.00	06000	LABORATORY	1,258,207	69,593	12,353	22,483	1,362,636	60.00
65.00	06500	RESPIRATORY THERAPY	309,179	92,129	31,155	9,738	442,201	65.00
66.00	06600	PHYSICAL THERAPY	640,481	134,791	15,139	21,213	811,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,840	8,221	0	5,741	182,802	67.00
69.00	06900	ELECTROCARDIOLOGY	84,419	0	0	2,594	87,013	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	207,871	39,072	1,137	3,072	251,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,613	0	0	0	32,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	861,620	30,426	1,872	8,179	902,097	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	780,868	0	2,005	21,399	804,272	88.00
88.01	08801	RHC - GIRARD	260,487	0	0	6,656	267,143	88.01
90.00	09000	CLINIC	379,283	120,618	3,203	6,611	509,715	90.00
91.00	09100	EMERGENCY	1,220,346	104,318	25,688	27,776	1,378,128	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 1-117)	18,288,787	2,685,007	542,808	297,871	18,276,475	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,646	22	0	8,668	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	1,751	0	0	0	1,751	194.00
194.01	07951	FUND DEVELOPMENT	24,337	2,882	337	425	27,981	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 118-201)	18,314,875	2,696,535	543,167	298,296	18,314,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B Part I | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,254,432					5.00
7.00	00700	OPERATION OF PLANT	296,372	1,275,850				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,103	0	73,627			8.00
9.00	00900	HOUSEKEEPING	84,878	12,668	0	378,060		9.00
10.00	01000	DIETARY	123,207	48,769	0	13,028	592,189	10.00
11.00	01100	CAFETERIA	20,686	49,143	0	13,128	359,424	11.00
13.00	01300	NURSING ADMINISTRATION	139,013	8,049	0	2,150	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,660	36,305	0	9,699	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	64,944	2,683	0	717	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	538,922	380,645	35,764	101,688	232,765	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	238,535	178,640	4,725	47,722	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,917	119,954	6,858	32,045	0	54.00
60.00	06000	LABORATORY	412,309	50,026	0	13,364	0	60.00
65.00	06500	RESPIRATORY THERAPY	133,802	66,226	241	17,692	0	65.00
66.00	06600	PHYSICAL THERAPY	245,583	96,894	3,278	25,884	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	55,313	5,909	0	1,579	0	67.00
69.00	06900	ELECTROCARDIOLOGY	26,329	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,994	28,087	0	7,503	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,868	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,958	21,872	0	5,843	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	243,358	0	32	15,768	0	88.00
88.01	08801	RHC - GIRARD	80,833	0	0	24,841	0	88.01
90.00	09000	CLINIC	154,231	86,705	0	23,163	0	90.00
91.00	09100	EMERGENCY	416,997	74,988	22,729	20,033	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 1-117)	4,242,812	1,267,563	73,627	375,847	592,189	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,623	6,215	0	1,660	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	530	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	8,467	2,072	0	553	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 118-201)	4,254,432	1,275,850	73,627	378,060	592,189	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B Part I | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	510,745					11.00
13.00	01300	NURSING ADMINISTRATION	23,596	632,231				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,316	0	516,261			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	5,250	13,534	4,828	306,589		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,746	303,569	27,358	0	3,519,554	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,279	39,389	13,396	0	1,326,019	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	306,589	306,589	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,491	0	141,440	0	2,453,520	54.00
60.00	06000	LABORATORY	57,752	0	113,704	0	2,009,791	60.00
65.00	06500	RESPIRATORY THERAPY	32,445	0	16,691	0	709,298	65.00
66.00	06600	PHYSICAL THERAPY	42,887	0	38,429	0	1,264,579	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,267	0	9,815	0	266,685	67.00
69.00	06900	ELECTROCARDIOLOGY	5,191	0	12,218	0	130,751	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,675	0	14,731	0	387,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,017	0	43,498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,341	42,131	31,380	0	1,292,622	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	7,905	0	1,071,335	88.00
88.01	08801	RHC - GIRARD	0	0	3,810	0	376,627	88.01
90.00	09000	CLINIC	20,411	52,624	9,976	0	856,825	90.00
91.00	09100	EMERGENCY	70,199	180,984	69,563	0	2,233,621	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 1-117)	504,846	632,231	516,261	306,589	18,248,456	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	19,166	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	2,281	194.00
194.01	07951	FUND DEVELOPMENT	5,899	0	0	0	44,972	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	510,745	632,231	516,261	306,589	18,314,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B Part I | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,519,554		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,326,019		50.00
53.00	05300	ANESTHESIOLOGY	0	306,589		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,453,520		54.00
60.00	06000	LABORATORY	0	2,009,791		60.00
65.00	06500	RESPIRATORY THERAPY	0	709,298		65.00
66.00	06600	PHYSICAL THERAPY	0	1,264,579		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	266,685		67.00
69.00	06900	ELECTROCARDIOLOGY	0	130,751		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	387,142		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	43,498		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,292,622		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	1,071,335		88.00
88.01	08801	RHC - GIRARD	0	376,627		88.01
90.00	09000	CLINIC	0	856,825		90.00
91.00	09100	EMERGENCY	0	2,233,621		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,248,456		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	19,166		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	2,281		194.00
194.01	07951	FUND DEVELOPMENT	0	44,972		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	18,314,875		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B Part II Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,668	544,977	80,406	656,051	0	5.00
7.00	00700	OPERATION OF PLANT	0	376,688	18,581	395,269	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	17,623	20	17,643	0	9.00
10.00	01000	DIETARY	1,591	67,844	19,171	88,606	0	10.00
11.00	01100	CAFETERIA	0	68,364	0	68,364	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,197	715	11,912	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50,505	5,197	55,702	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	3,732	40	3,772	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,618	529,527	40,986	588,131	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,976	248,511	64,287	506,774	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,056	166,871	220,853	406,780	0	54.00
60.00	06000	LABORATORY	68,036	69,593	12,353	149,982	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,624	92,129	31,155	130,908	0	65.00
66.00	06600	PHYSICAL THERAPY	0	134,791	15,139	149,930	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,221	0	8,221	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,072	1,137	40,209	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,857	30,426	1,872	115,155	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	28,374	0	2,005	30,379	0	88.00
88.01	08801	RHC - GIRARD	24,642	0	0	24,642	0	88.01
90.00	09000	CLINIC	0	120,618	3,203	123,821	0	90.00
91.00	09100	EMERGENCY	0	104,318	25,688	130,006	0	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 1-117)	474,442	2,685,007	542,808	3,702,257	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,646	22	8,668	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	2,882	337	3,219	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	474,442	2,696,535	543,167	3,714,144	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B Part II Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	656,051					5.00
7.00	00700	OPERATION OF PLANT	45,701	440,970				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,637	0	2,637			8.00
9.00	00900	HOUSEKEEPING	13,089	4,378	0	35,110		9.00
10.00	01000	DIETARY	18,999	16,856	0	1,210	125,671	10.00
11.00	01100	CAFETERIA	3,190	16,985	0	1,219	76,275	11.00
13.00	01300	NURSING ADMINISTRATION	21,436	2,782	0	200	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,831	12,548	0	901	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	10,015	927	0	67	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,106	131,564	1,281	9,443	49,396	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,783	61,743	169	4,432	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,392	41,459	246	2,976	0	54.00
60.00	06000	LABORATORY	63,579	17,290	0	1,241	0	60.00
65.00	06500	RESPIRATORY THERAPY	20,633	22,890	9	1,643	0	65.00
66.00	06600	PHYSICAL THERAPY	37,870	33,489	117	2,404	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,529	2,042	0	147	0	67.00
69.00	06900	ELECTROCARDIOLOGY	4,060	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,719	9,708	0	697	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,522	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,091	7,559	0	543	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	37,527	0	1	1,464	0	88.00
88.01	08801	RHC - GIRARD	12,465	0	0	2,307	0	88.01
90.00	09000	CLINIC	23,783	29,968	0	2,151	0	90.00
91.00	09100	EMERGENCY	64,302	25,918	814	1,860	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 1-117)	654,259	438,106	2,637	34,905	125,671	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	404	2,148	0	154	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	82	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	1,306	716	0	51	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 118-201)	656,051	440,970	2,637	35,110	125,671	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B Part II | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	166,033					11.00
13.00	01300	NURSING ADMINISTRATION	7,671	44,001				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,205	0	94,187			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,707	942	881	18,311		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,276	21,128	4,992		927,317	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,967	2,741	2,444		620,053	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,763	0	25,795		568,411	54.00
60.00	06000	LABORATORY	18,774	0	20,747		271,613	60.00
65.00	06500	RESPIRATORY THERAPY	10,547	0	3,046		189,676	65.00
66.00	06600	PHYSICAL THERAPY	13,942	0	7,012		244,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,663	0	1,791		24,393	67.00
69.00	06900	ELECTROCARDIOLOGY	1,688	0	2,229		7,977	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,145	0	2,688		68,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	186		1,708	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,312	2,932	5,726		179,318	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	1,442		70,813	88.00
88.01	08801	RHC - GIRARD	0	0	695		40,109	88.01
90.00	09000	CLINIC	6,635	3,662	1,820		191,840	90.00
91.00	09100	EMERGENCY	22,820	12,596	12,693		271,009	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 1-117)	164,115	44,001	94,187	0	3,677,167	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		11,374	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		82	194.00
194.01	07951	FUND DEVELOPMENT	1,918	0	0		7,210	194.01
200.00		Cross Foot Adjustments				18,311	18,311	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	166,033	44,001	94,187	18,311	3,714,144	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B Part II | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	927,317		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	620,053		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	568,411		54.00
60.00	06000	LABORATORY	0	271,613		60.00
65.00	06500	RESPIRATORY THERAPY	0	189,676		65.00
66.00	06600	PHYSICAL THERAPY	0	244,764		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	24,393		67.00
69.00	06900	ELECTROCARDIOLOGY	0	7,977		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	68,166		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,708		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	179,318		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	70,813		88.00
88.01	08801	RHC - GIRARD	0	40,109		88.01
90.00	09000	CLINIC	0	191,840		90.00
91.00	09100	EMERGENCY	0	271,009		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,677,167		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,374		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	82		194.00
194.01	07951	FUND DEVELOPMENT	0	7,210		194.01
200.00		Cross Foot Adjustments	0	18,311		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	3,714,144		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B-1 | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	57,075					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		452,455				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,247,250			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,535	66,978	1,252,354	-4,254,432	14,060,443	5.00
7.00	00700	OPERATION OF PLANT	7,973	15,478	203,880	0	979,478	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	56,524	8.00
9.00	00900	HOUSEKEEPING	373	17	184,685	0	280,514	9.00
10.00	01000	DIETARY	1,436	15,969	144,804	0	407,185	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	68,364	11.00
13.00	01300	NURSING ADMINISTRATION	237	596	359,709	0	459,423	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	4,329	169,732	0	339,281	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	33	180,331	0	214,633	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	34,141	859,374	0	1,781,097	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	53,551	153,184	0	788,333	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	183,969	437,758	0	1,615,815	54.00
60.00	06000	LABORATORY	1,473	10,290	546,237	0	1,362,636	60.00
65.00	06500	RESPIRATORY THERAPY	1,950	25,952	236,596	0	442,201	65.00
66.00	06600	PHYSICAL THERAPY	2,853	12,611	515,383	0	811,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	0	139,475	0	182,802	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	63,013	0	87,013	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	947	74,641	0	251,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	32,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	1,559	198,709	0	902,097	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	1,670	519,894	0	804,272	88.00
88.01	08801	RHC - GIRARD	0	0	161,710	0	267,143	88.01
90.00	09000	CLINIC	2,553	2,668	160,627	0	509,715	90.00
91.00	09100	EMERGENCY	2,208	21,398	674,818	0	1,378,128	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 1-117)	56,831	452,156	7,236,914	-4,254,432	14,022,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	8,668	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	1,751	194.00
194.01	07951	FUND DEVELOPMENT	61	281	10,336	0	27,981	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)	2,696,535	543,167	298,296		4,254,432	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.245466	1.200488	0.041160		0.302582	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		656,051	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.046659	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B-1 | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	37,567					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	92,717				8.00
9.00	00900	HOUSEKEEPING	373	0	41,670			9.00
10.00	01000	DIETARY	1,436	0	1,436	25,271		10.00
11.00	01100	CAFETERIA	1,447	0	1,447	15,338	8,658	11.00
13.00	01300	NURSING ADMINISTRATION	237	0	237	0	400	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	0	1,069	0	480	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	89	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	45,038	11,208	9,933	1,996	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	5,950	5,260	0	259	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	8,636	3,532	0	822	54.00
60.00	06000	LABORATORY	1,473	0	1,473	0	979	60.00
65.00	06500	RESPIRATORY THERAPY	1,950	303	1,950	0	550	65.00
66.00	06600	PHYSICAL THERAPY	2,853	4,128	2,853	0	727	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	0	174	0	191	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	88	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	0	827	0	164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	0	644	0	277	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	40	1,738	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	2,738	0	0	88.01
90.00	09000	CLINIC	2,553	0	2,553	0	346	90.00
91.00	09100	EMERGENCY	2,208	28,622	2,208	0	1,190	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 1-117)	37,323	92,717	41,426	25,271	8,558	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	0	183	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	0	61	0	100	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,275,850	73,627	378,060	592,189	510,745	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.961988	0.794105	9.072714	23.433540	58.991106	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	440,970	2,637	35,110	125,671	166,033	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.738228	0.028441	0.842573	4.972933	19.176831	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet B-1 | Date/Time Prepared: 12/18/2015 10:10 am

		Cost Center Description	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	86,466				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,261,981			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,851	311,035	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	41,517	1,762,636	0		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,387	863,097	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,112,746	0		54.00
60.00	06000	LABORATORY	0	7,325,816	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,075,397	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,475,922	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	632,374	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	787,194	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	949,117	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,525	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,762	2,021,758	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	509,284	0		88.00
88.01	08801	RHC - GIRARD	0	245,493	0		88.01
90.00	09000	CLINIC	7,197	642,742	0		90.00
91.00	09100	EMERGENCY	24,752	4,481,845	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,466	33,261,981	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	0	0	0		194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	632,231	516,261	306,589		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.311903	0.015521	3,065.890000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,001	94,187	18,311		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.508882	0.002832	183.110000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,519,554		3,519,554	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,326,019		1,326,019	0	0	50.00
53.00	05300	ANESTHESIOLOGY	306,589		306,589	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,453,520		2,453,520	0	0	54.00
60.00	06000	LABORATORY	2,009,791		2,009,791	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	709,298	0	709,298	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,264,579	0	1,264,579	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	266,685	0	266,685	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	130,751		130,751	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	387,142		387,142	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,498		43,498	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,292,622		1,292,622	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	1,071,335		1,071,335	0	0	88.00
88.01	08801	RHC - GIRARD	376,627		376,627	0	0	88.01
90.00	09000	CLINIC	856,825		856,825	0	0	90.00
91.00	09100	EMERGENCY	2,233,621		2,233,621	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	285,360		285,360		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)	18,533,816	0	18,533,816	0	0	200.00
201.00		Less Observation Beds	285,360		285,360		0	201.00
202.00		Total (see instructions)	18,248,456	0	18,248,456	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,392,212		1,392,212			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	863,097	863,097	1.536350	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	311,035	311,035	0.985706	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	480,281	8,632,465	9,112,746	0.269240	0.000000	54.00
60.00	06000	LABORATORY	620,590	6,705,226	7,325,816	0.274344	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	204,007	871,390	1,075,397	0.659569	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	370,558	2,105,364	2,475,922	0.510751	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	333,981	298,393	632,374	0.421720	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	33,051	754,143	787,194	0.166098	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	418,333	530,784	949,117	0.407897	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,525	65,525	0.663838	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	840,820	1,180,938	2,021,758	0.639355	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	509,284	509,284			88.00
88.01	08801	RHC - GIRARD	0	245,493	245,493			88.01
90.00	09000	CLINIC	2,000	640,742	642,742	1.333078	0.000000	90.00
91.00	09100	EMERGENCY	81,943	4,399,902	4,481,845	0.498371	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,045	362,379	370,424	0.770360	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)	4,785,821	28,476,160	33,261,981			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,785,821	28,476,160	33,261,981			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet C Part I Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		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
		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: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D Part II Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	620,053	863,097	0.718405	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	311,035	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	568,411	9,112,746	0.062375	279,686	17,445	54.00
60.00	06000	LABORATORY	271,613	7,325,816	0.037076	339,689	12,594	60.00
65.00	06500	RESPIRATORY THERAPY	189,676	1,075,397	0.176378	93,314	16,459	65.00
66.00	06600	PHYSICAL THERAPY	244,764	2,475,922	0.098858	59,868	5,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,393	632,374	0.038574	27,998	1,080	67.00
69.00	06900	ELECTROCARDIOLOGY	7,977	787,194	0.010133	19,110	194	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	68,166	949,117	0.071820	182,327	13,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,708	65,525	0.026066	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	179,318	2,021,758	0.088694	329,297	29,207	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	70,813	509,284	0.139044	0	0	88.00
88.01	08801	RHC - GIRARD	40,109	245,493	0.163381	0	0	88.01
90.00	09000	CLINIC	191,840	642,742	0.298471	0	0	90.00
91.00	09100	EMERGENCY	271,009	4,481,845	0.060468	10,832	655	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	150,906	370,424	0.407387	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,900,756	31,869,769		1,342,121	96,647	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D Part IV Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	306,589	0	0	0	306,589	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	306,589	0	0	0	306,589	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D Part IV Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	863,097	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	311,035	0.985706	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,112,746	0.000000	0.000000	279,686	54.00
60.00	06000	LABORATORY	0	7,325,816	0.000000	0.000000	339,689	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,075,397	0.000000	0.000000	93,314	65.00
66.00	06600	PHYSICAL THERAPY	0	2,475,922	0.000000	0.000000	59,868	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	632,374	0.000000	0.000000	27,998	67.00
69.00	06900	ELECTROCARDIOLOGY	0	787,194	0.000000	0.000000	19,110	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	949,117	0.000000	0.000000	182,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,525	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,021,758	0.000000	0.000000	329,297	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	509,284	0.000000	0.000000	0	88.00
88.01	08801	RHC - GIRARD	0	245,493	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	642,742	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,481,845	0.000000	0.000000	10,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	370,424	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	31,869,769			1,342,121	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D Part IV Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	0	0		88.00
88.01	08801	RHC - GIRARD	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D Part V Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.536350	0	491,953	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.985706	0	190,830	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269240	0	3,450,762	0	0	54.00
60.00	06000	LABORATORY	0.274344	0	3,058,325	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.659569	0	449,093	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.510751	0	746,606	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421720	0	66,787	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.166098	0	398,838	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.407897	0	280,111	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.663838	0	49,022	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.639355	0	797,956	0	0	73.00
		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	1.333078	0	482,691	0	0	90.00
91.00	09100	EMERGENCY	0.498371	0	1,530,695	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770360	0	175,845	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	12,169,514	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	12,169,514	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D Part V Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	755,812	0		50.00
53.00	05300	ANESTHESIOLOGY	188,102	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	929,083	0		54.00
60.00	06000	LABORATORY	839,033	0		60.00
65.00	06500	RESPIRATORY THERAPY	296,208	0		65.00
66.00	06600	PHYSICAL THERAPY	381,330	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,165	0		67.00
69.00	06900	ELECTROCARDIOLOGY	66,246	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,256	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,543	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510,177	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	0		88.00
88.01	08801	RHC - GIRARD	0	0		88.01
90.00	09000	CLINIC	643,465	0		90.00
91.00	09100	EMERGENCY	762,854	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	135,464	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,682,738	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,682,738	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D Part V | Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.536350	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.985706	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269240	0	0	0	0	54.00
60.00	06000	LABORATORY	0.274344	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.659569	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.510751	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421720	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.166098	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.407897	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.663838	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.639355	0	0	0	0	73.00
		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	1.333078	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.498371	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770360	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: 141347 | Component CCN: 14Z347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D Part V | Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	0		88.00
88.01	08801	RHC - GIRARD	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,511	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,229	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)	1,029	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	514	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)	719	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	49	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	770	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)	454	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)	635	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	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	138.58	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,519,554	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	6,790	25.00
26.00	Total swing-bed cost (see instructions)	1,766,022	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,753,532	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,753,532	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)	1,426.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,098,628	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)	1,098,628	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	565,908	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,664,536	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)	647,763	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	906,012	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,553,775	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)	200	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,426.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	285,360	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D-1 | Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	927,317	1,753,532	0.528828	285,360	150,906	90.00
91.00	Nursing School cost	0	1,753,532	0.000000	285,360	0	91.00
92.00	Allied health cost	0	1,753,532	0.000000	285,360	0	92.00
93.00	All other Medical Education	0	1,753,532	0.000000	285,360	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D-3 | Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		635,285		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.536350	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.985706	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269240	279,686	75,303	54.00
60.00	06000	LABORATORY	0.274344	339,689	93,192	60.00
65.00	06500	RESPIRATORY THERAPY	0.659569	93,314	61,547	65.00
66.00	06600	PHYSICAL THERAPY	0.510751	59,868	30,578	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421720	27,998	11,807	67.00
69.00	06900	ELECTROCARDIOLOGY	0.166098	19,110	3,174	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.407897	182,327	74,371	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.663838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.639355	329,297	210,538	73.00
		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	1.333078	0	0	90.00
91.00	09100	EMERGENCY	0.498371	10,832	5,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770360	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,342,121	565,908	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)		1,342,121		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet D-3 | Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.536350	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.985706	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269240	88,354	23,788	54.00
60.00	06000	LABORATORY	0.274344	154,965	42,514	60.00
65.00	06500	RESPIRATORY THERAPY	0.659569	66,603	43,929	65.00
66.00	06600	PHYSICAL THERAPY	0.510751	256,339	130,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421720	261,320	110,204	67.00
69.00	06900	ELECTROCARDIOLOGY	0.166098	3,901	648	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.407897	174,537	71,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.663838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.639355	305,468	195,302	73.00
		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	1.333078	1,324	1,765	90.00
91.00	09100	EMERGENCY	0.498371	5,416	2,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770360	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,318,227	622,967	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)		1,318,227		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2014 To 07/31/2015	Worksheet E Part B Date/Time Prepared: 12/18/2015 10:10 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,682,738	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,682,738	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,739,565	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	38,065	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,827,571	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)	3,873,929	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)	3,873,929	30.00
31.00	Primary payer payments	1,472	31.00
32.00	Subtotal (line 30 minus line 31)	3,872,457	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)	238,886	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	181,553	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	209,995	36.00
37.00	Subtotal (see instructions)	4,054,010	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,054,010	40.00
40.01	Sequestration adjustment (see instructions)	81,080	40.01
41.00	Interim payments	3,944,883	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	28,047	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 12/18/2015 10:10 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,205,513		3,619,802	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	03/13/2015	95,016	03/13/2015	116,533	3.01
3.02		07/29/2015	122,535		0	3.02
3.03		07/31/2015	29,330	07/31/2015	270,403	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	07/29/2015	61,855	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)		246,881		325,081	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)		1,452,394		3,944,883	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		14,429		28,047	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,466,823		3,972,930	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: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet E-1 Part I
Component CCN: 14Z347 | Date/Time Prepared: 12/18/2015 10:10 am
Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,978,669		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	03/13/2015	13,218		0	3.01
3.02		07/29/2015	164,153		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)		177,371		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)		2,156,040		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		26,691		0	6.02
7.00	Total Medicare program liability (see instructions)		2,129,349		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: 141347	Period: From 08/01/2014 To 07/31/2015	Worksheet E-1 Part II Date/Time Prepared: 12/18/2015 10:10 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	316	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	770	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	98	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,029	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	33,261,981	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	301,241	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	148,020	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	148,020	8.00
9.00	Sequestration adjustment amount (see instructions)	2,960	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	145,060	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	145,060	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141347 Component CCN: 14Z347	Period: From 08/01/2014 To 07/31/2015	Worksheet E-2 Date/Time Prepared: 12/18/2015 10:10 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,569,313	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	629,197	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,089	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)	2,198,510	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,198,510	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)	2,198,510	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	25,705	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,172,805	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,172,805	0	19.00
19.01	Sequestration adjustment (see instructions)	43,456	0	19.01
20.00	Interim payments	2,156,040	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-26,691	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2014 To 07/31/2015	Worksheet E-3 Part V Date/Time Prepared: 12/18/2015 10:10 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,664,536	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)	1,664,536	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,681,181	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)	1,681,181	19.00
20.00	Deductibles (exclude professional component)	216,406	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,464,775	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,464,775	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42,083	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	31,983	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,633	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,496,758	28.00
29.00	-14011	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,496,758	30.00
30.01	Sequestration adjustment (see instructions)	29,935	30.01
31.00	Interim payments	1,452,394	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	14,429	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet G | Date/Time Prepared: 12/18/2015 10:10 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,360,218	0	0	0	1.00
2.00	Temporary investments	108,146	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,403,237	0	0	0	4.00
5.00	Other receivable	330,872	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-648,000	0	0	0	6.00
7.00	Inventory	188,895	0	0	0	7.00
8.00	Prepaid expenses	221,381	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)	7,964,749	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	517,172	0	0	0	12.00
13.00	Land improvements	1,314,635	0	0	0	13.00
14.00	Accumulated depreciation	-371,775	0	0	0	14.00
15.00	Buildings	19,812,583	0	0	0	15.00
16.00	Accumulated depreciation	-5,814,808	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	5,271,000	0	0	0	23.00
24.00	Accumulated depreciation	-3,702,400	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	-773,783	0	0	0	28.00
29.00	Minor equipment-nondepreciable	4,403,410	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	21,836,361	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	5,336,344	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	1,017,032	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,353,376	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,154,486	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,540,483	0	0	0	37.00
38.00	Salaries, wages, and fees payable	731,051	0	0	0	38.00
39.00	Payroll taxes payable	13,097	0	0	0	39.00
40.00	Notes and loans payable (short term)	697,785	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	251,004	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,233,420	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,223,284	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	50,311	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	17,273,595	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	20,507,015	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,647,471				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)	15,647,471	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,154,486	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet G-1 | Date/Time Prepared: 12/18/2015 10:10 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		13,334,793		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,313,298				2.00
3.00	Total (sum of line 1 and line 2)		15,648,091		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,648,091		0		11.00
12.00	DECREASE IN PERM RESTRICTED	620		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)		620		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,647,471		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			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: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/18/2015 10:10 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,265,106		1,265,106	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	538,020		538,020	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)	1,803,126		1,803,126	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)	1,803,126		1,803,126	17.00
18.00	Ancillary services	3,321,254	0	3,321,254	18.00
19.00	Outpatient services	0	29,608,807	29,608,807	19.00
20.00	RHC - CARLINVILLE	0	509,284	509,284	20.00
20.01	RHC - GIRARD	0	245,493	245,493	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)	5,124,380	30,363,584	35,487,964	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,993,426		29.00
30.00		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)		20,993,426		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141347 | Period: From 08/01/2014 To 07/31/2015 | Worksheet G-3 | Date/Time Prepared: 12/18/2015 10:10 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	35,487,964	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,617,635	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,870,329	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,993,426	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,123,097	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	54,874	6.00
7.00	Income from investments	56,699	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	17,073	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	59,745	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	23,693	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	353,235	24.01
24.02	PHYSICAL THERAPY - NON PATIENTS	0	24.02
24.03	OTHER	38,120	24.03
24.04		0	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	3,123,024	24.05
24.06	GRANTS	25,122	24.06
25.00	Total other income (sum of lines 6-24)	3,751,585	25.00
26.00	Total (line 5 plus line 25)	2,628,488	26.00
27.00	LOSS FROM DISPOSAL	315,190	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	315,190	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,313,298	29.00

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

Provider CCN: 141347 Component CCN: 148530 | Period: From 08/01/2014 To 07/31/2015 | Worksheet M-1 | Date/Time Prepared: 12/18/2015 10:10 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	212,625	0	212,625	0	212,625	1.00
2.00	Physician Assistant	79,182	0	79,182	0	79,182	2.00
3.00	Nurse Practitioner	57,937	0	57,937	0	57,937	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	200,700	121,551	322,251	108,873	431,124	9.00
10.00	Subtotal (sum of lines 1 through 9)	550,444	121,551	671,995	108,873	780,868	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	550,444	121,551	671,995	108,873	780,868	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	550,444	121,551	671,995	108,873	780,868	32.00

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

Provider CCN: 141347 Component CCN: 148530 | Period: From 08/01/2014 To 07/31/2015 | Worksheet M-1 | Date/Time Prepared: 12/18/2015 10:10 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	212,625		1.00
2.00	Physician Assistant	0	79,182		2.00
3.00	Nurse Practitioner	0	57,937		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	431,124		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	780,868		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	780,868		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	780,868		32.00

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

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2014 To 07/31/2015 | Worksheet M-1 | Date/Time Prepared: 12/18/2015 10:10 am

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	100,051	0	100,051	0	100,051	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	81,016	51,917	132,933	27,503	160,436	9.00
10.00	Subtotal (sum of lines 1 through 9)	181,067	51,917	232,984	27,503	260,487	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	181,067	51,917	232,984	27,503	260,487	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	181,067	51,917	232,984	27,503	260,487	32.00

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

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2014 To 07/31/2015 | Worksheet M-1 | Date/Time Prepared: 12/18/2015 10:10 am

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	100,051		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	160,436		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	260,487		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	260,487		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	260,487		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141347 Component CCN: 148530

Period: From 08/01/2014 To 07/31/2015

Worksheet M-2

Date/Time Prepared: 12/18/2015 10:10 am

Rural Health Clinic (RHC) I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.65	1,121	4,200	2,730		1.00
2.00	Physician Assistant	1.31	2,189	2,100	2,751		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.96	3,310		5,481	5,481	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.96	3,310			5,481	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					780,868	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					780,868	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					290,467	15.00
16.00	Total overhead (sum of lines 14 and 15)					290,467	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					290,467	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					290,467	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,071,335	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141347 | Component CCN: 148532 | Period: From 08/01/2014 To 07/31/2015 | Worksheet M-2 | Date/Time Prepared: 12/18/2015 10:10 am

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.86	1,311	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.86	1,311		1,806	1,806	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.86	1,311			1,806	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	260,487	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	260,487	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	116,140	15.00
16.00	Total overhead (sum of lines 14 and 15)	116,140	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	116,140	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	116,140	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	376,627	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141347 Component CCN: 148530	Period: From 08/01/2014 To 07/31/2015	Worksheet M-3 Date/Time Prepared: 12/18/2015 10:10 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,071,335	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		322	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,071,013	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,481	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)		5,481	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		195.40	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	195.40	195.40	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,140	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	222,756	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		222,756	16.00
16.01	Total program charges (see instructions)(from contractor's records)		119,740	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,709	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,179	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.)		165,238	16.04
16.05	Total program cost (see instructions)		168,417	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,030	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,000	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		168,417	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		274	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		168,691	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
26.00	Net reimbursable amount (see instructions)		168,691	26.00
26.01	Sequestration adjustment (see instructions)		3,374	26.01
27.00	Interim payments		154,276	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		11,041	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141347 Component CCN: 148532	Period: From 08/01/2014 To 07/31/2015	Worksheet M-3 Date/Time Prepared: 12/18/2015 10:10 am
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		376,627	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		32	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		376,595	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,806	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)		1,806	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		208.52	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	208.52	208.52	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	325	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	67,769	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		67,769	16.00
16.01	Total program charges (see instructions)(from contractor's records)		48,740	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		50,310	16.04
16.05	Total program cost (see instructions)		50,310	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,881	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,772	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		50,310	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		32	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		50,342	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
26.00	Net reimbursable amount (see instructions)		50,342	26.00
26.01	Sequestration adjustment (see instructions)		1,007	26.01
27.00	Interim payments		44,899	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		4,436	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 PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141347 Component CCN: 148530	Period: From 08/01/2014 To 07/31/2015	Worksheet M-4 Date/Time Prepared: 12/18/2015 10:10 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	780,868	780,868	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000094	0.000208	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	73	162	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	73	162	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	780,868	780,868	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	290,467	290,467	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000093	0.000207	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	27	60	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	100	222	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	19	42	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	5.26	5.29	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	16	36	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	84	190	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		322	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		274	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141347 Component CCN: 148532	Period: From 08/01/2014 To 07/31/2015	Worksheet M-4 Date/Time Prepared: 12/18/2015 10:10 am
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	260,487	260,487	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000086	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	22	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	22	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	260,487	260,487	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	116,140	116,140	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000084	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	10	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	32	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	6	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	5.33	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	6	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	32	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		32	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		32	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141347 Component CCN: 148530	Period: From 08/01/2014 To 07/31/2015	Worksheet M-5 Date/Time Prepared: 12/18/2015 10:10 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		132,192	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/13/2015	6,006	3.01
3.02		07/29/2015	16,078	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)		22,084	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		154,276	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		11,041	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		165,317	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: 141347 Component CCN: 148532	Period: From 08/01/2014 To 07/31/2015	Worksheet M-5 Date/Time Prepared: 12/18/2015 10:10 am
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		44,677	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/13/2015	4,319	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		07/29/2015	4,097	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)		222	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		44,899	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		4,436	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		49,335	7.00

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