

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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet S Parts I-III Date/Time Prepared: 12/27/2018 9:08 am
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 12/27/2018 Time: 9:08 am

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARLINVILLE AREA HOSPITAL (14-1347) for the cost reporting period beginning 08/01/2017 and ending 07/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Encryption Information

ECR: Date: 12/27/2018 Time: 9:08 am
 x5ZT0mju96Gy5LntJy.2dHiGq8HqJ0
 69uPq0GLOC5Hx.cj3c0h9uEwgZjFOIW
 KSfo040Qqr0k6m:X
 PI: Date: 12/27/2018 Time: 9:08 am
 sqQjNkjh1kNo5leLAZwpl3F1sxAen0
 .58TQ0wfvbwsW4eIdw6o7aTp.4gv7x
 tyBg09poe20F6ldh

(Signed) *Richard Schen*
 Officer or Administrator of Provider(s)

BOARD CHAIRMAN
 Title

12/28/2018
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	148,359	-440,886	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	184,429	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RHC - CARLINVILLE I	0		22,626		0	10.00
10.01 RHC - GIRARD II	0		-3,759		0	10.01
200.00 Total	0	332,788	-422,019	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 2:20 pm
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1.00	Hospital and Hospital Health Care Complex Address:		2.00	3.00	4.00
1.00	Street: 20733 NORTH BROAD STREET		PO Box:		
2.00	City: CARLINVILLE	State: IL	Zip Code: 62626-	County: MACOUPIN	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	CARLINVILLE AREA HOSPITAL	141347	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	142347	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:
20.00	Cost Reporting Period (mm/dd/yyyy)	1.00 08/01/2017	2.00 07/31/2018
21.00	Type of Control (see instructions)	2	

	1.00	2.00	3.00
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Inpatient PPS Information		1.00	2.00	3.00	
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.		2	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347		Period: From 08/01/2017 To 07/31/2018		Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 2:20 pm	
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0	35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0	37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N	37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	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	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(b) 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

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00		62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N		63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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

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				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00		
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00		
				V 1.00	XIX 2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06		
Rural Providers							
105.00	Does this hospital qualify as a CAH?		Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y		108.00		
				Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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	Y	109.00
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 2:20 pm
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111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	1.00 N	2.00	111.00
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		1.00	2.00	3.00
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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:	208,248	0	0	118.01
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		1.00	2.00
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118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.	N			122.00

Transplant Center Information

125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00

All Providers

140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 2:20 pm
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		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.								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		
								1.00		
165.00	Multicampus 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)								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)							10/01/2016	09/30/2017	170.00
								1.00		
								2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet S-2 Part II Date/Time Prepared: 12/21/2018 2:20 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/06/2018	Y	11/06/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet S-2 Part II Date/Time Prepared: 12/21/2018 2:20 pm
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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost

22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00

Interest Expense

28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00

Purchased Services

32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00

Provider-Based Physicians

34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00

Y/N	Date
1.00	2.00

Home Office Costs

36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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
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Cost Report Preparer Contact Information

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet S-2 Part II Date/Time Prepared: 12/21/2018 2:20 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P	Title V
	Line Number		Available		Visits / Trips	
	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	29,904.00	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	29,904.00	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	29,904.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC - CARLINVILLE	88.00				0	26.00
26.01 RHC - GIRARD	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

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)	909	119	1,246			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,141	0	1,355			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	85			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,050	119	2,686			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)	2,050	119	2,686	0.00	141.57	14.00
15.00 CAH visits	13,347	3,982	23,894			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	2,154	3,544	10,473	0.00	21.60	26.00
26.01 RHC - GIRARD	410	792	2,055	0.00	3.60	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	166.77	27.00
28.00 Observation Bed Days		89	417			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	306	50	438	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	306		50	438	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RHC - CARLINVILLE	0.00						26.00
26.01 RHC - GIRARD	0.00						26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2017 To 07/31/2018	Worksheet S-8 Date/Time Prepared: 12/21/2018 2:20 pm
		RHC I	Cost

		1.00			
1.00	Clinic Address and Identification	1115 EAST MORGAN STREET, #2			1.00
	Street	City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CARLINVILLE IL 62626			2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0			3.00
		Grant Award	Date		
		1.00	2.00		
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00			2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N			0 10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		5.00			
11.00	Facility hours of operations (1)	CLINIC			11.00
		07:30		16:00	07:30
		1.00			2.00
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N			0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
					Total Visits
					5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County			
		4.00			
2.00	City, State, ZIP Code, County	MACOUPIN			2.00
		Tuesday	wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
					10.00
11.00	Facility hours of operations (1)	CLINIC			11.00
		16:00	07:30	16:00	07:30
					16:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 08/01/2017
To 07/31/2018

Worksheet S-8
Date/Time Prepared:
12/21/2018 2:20 pm

		RHC I		Cost		
		Friday		Saturday		
		from	to	from	to	
11.00	Facility hours of operations (1) CLINIC	07:30	16:00	13.00	14.00	11.00

		RHC II		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	205 SOUTH THRID STREET				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	GIRARD		IL 62640		2.00
				1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00
		Grant Award		Date		
		1.00		2.00		
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00		
				2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)					11.00
	CLINIC	08:00		17:00		08:00
				1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number	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
11.00	Facility hours of operations (1)					11.00
	CLINIC	17:00	08:00	17:00	08:00	17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

worksheet S-8

Component CCN: 14-8532

Date/Time Prepared:
12/21/2018 2:20 pm

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

		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)	0.464423	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	2,795,416	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,840,553	5.00
6.00	Medicaid charges	9,767,369	6.00
7.00	Medicaid cost (line 1 times line 6)	4,536,191	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)			
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	45,939	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	
		3.00	
Uncompensated Care (see instructions for each line)			
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	376,074	0
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	174,657	0
22.00	Payments received from patients for amounts previously written off as charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	174,657	0
		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	706,591	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	242,208	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	372,628	27.01
28.00	Non-Medicare bad debt expense (see instructions)	333,963	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	285,520	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	460,177	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	460,177	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet A

Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,674,507	1,674,507	750,035	2,424,542	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		481,283	481,283	16,253	497,536	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,095,495	2,095,495	0	2,095,495	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,354,484	2,685,882	4,040,366	112,526	4,152,892	5.00
7.00	00700	OPERATION OF PLANT	218,214	477,160	695,374	0	695,374	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,642	178,642	0	178,642	8.00
9.00	00900	HOUSEKEEPING	279,709	38,944	318,653	0	318,653	9.00
10.00	01000	DIETARY	179,555	224,847	404,402	0	404,402	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	323,455	17,573	341,028	0	341,028	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	156,196	71,782	227,978	0	227,978	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	185,122	5,723	190,845	0	190,845	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	905,031	254,186	1,159,217	0	1,159,217	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	329,009	684,634	1,013,643	0	1,013,643	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	462,356	973,283	1,435,639	136	1,435,775	54.00
60.00	06000	LABORATORY	586,942	748,552	1,335,494	0	1,335,494	60.00
65.00	06500	RESPIRATORY THERAPY	353,660	239,966	593,626	0	593,626	65.00
66.00	06600	PHYSICAL THERAPY	897,986	78,474	976,460	0	976,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	221,534	5,877	227,411	0	227,411	67.00
69.00	06900	ELECTROCARDIOLOGY	91,690	102,391	194,081	0	194,081	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,215	170,428	258,643	0	258,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,226	42,226	0	42,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	220,358	827,970	1,048,328	0	1,048,328	73.00
76.00	03550	BEHAVIORIAL HEALTH	147,921	107,765	255,686	0	255,686	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	1,337,955	235,080	1,573,035	-142,450	1,430,585	88.00
88.01	08801	RHC - GIRARD	242,936	50,597	293,533	-44,229	249,304	88.01
90.00	09000	CLINIC	225,705	155,766	381,471	0	381,471	90.00
91.00	09100	EMERGENCY	1,180,494	1,708,182	2,888,676	0	2,888,676	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		692,271	692,271	-692,271	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,988,527	15,029,486	25,018,013	0	25,018,013	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	181,013	181,013	0	181,013	194.00
194.01	07951	FUND DEVELOPMENT	12,528	532	13,060	0	13,060	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	10,001,055	15,211,031	25,212,086	0	25,212,086	200.00

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	-163,884	2,260,658	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-1,550	495,986	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2,095,495	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-191,158	3,961,734	5.00
7.00	00700 OPERATION OF PLANT	-110	695,264	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	178,642	8.00
9.00	00900 HOUSEKEEPING	0	318,653	9.00
10.00	01000 DIETARY	-72,714	331,688	10.00
11.00	01100 CAFETERIA	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	341,028	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-7,794	220,184	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	190,845	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1,159,217	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-265,546	748,097	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-26,790	1,408,985	54.00
60.00	06000 LABORATORY	-300	1,335,194	60.00
65.00	06500 RESPIRATORY THERAPY	-1,616	592,010	65.00
66.00	06600 PHYSICAL THERAPY	-8,445	968,015	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	227,411	67.00
69.00	06900 ELECTROCARDIOLOGY	-46,150	147,931	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	258,643	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	42,226	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-46,307	1,002,021	73.00
76.00	03550 BEHAVIORIAL HEALTH	0	255,686	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC - CARLINVILLE	0	1,430,585	88.00
88.01	08801 RHC - GIRARD	0	249,304	88.01
90.00	09000 CLINIC	-42,885	338,586	90.00
91.00	09100 EMERGENCY	-1,431,993	1,456,683	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0	113.00
116.00	11600 HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-2,307,242	22,710,771	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950 NONREIMBURSABLE COSTS CENTERS	0	181,013	194.00
194.01	07951 FUND DEVELOPMENT	0	13,060	194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	-2,307,242	22,904,844	200.00

RECLASSIFICATIONS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet A-6

Date/Time Prepared:
12/21/2018 2:20 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
	B - RECLASS PHYSICIAN SALARY EXPENSE					
1.00			0.00	0	0	1.00
	TOTALS			0	0	
	C - INSURANCE EXPENSE					
1.00	OTHER CAPITAL RELATED COSTS		3.00	0	74,153	1.00
	TOTALS			0	74,153	
	E - INTEREST EXPENSE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC		54.00	0	136	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	692,135	2.00
	TOTALS			0	692,271	
	L - RECLASS RHC ADMIN SALARIES TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL		5.00	186,679	0	1.00
2.00			0.00	0	0	2.00
	TOTALS			186,679	0	
500.00	Grand Total: Increases			186,679	766,424	500.00

RECLASSIFICATIONS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet A-6

Date/Time Prepared:
12/21/2018 2:20 pm

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	B - RECLASS PHYSICIAN SALARY EXPENSE					
1.00		0.00	0	0	0	1.00
	TOTALS		0	0		
	C - INSURANCE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	74,153	0	1.00
	TOTALS		0	74,153		
	E - INTEREST EXPENSE RECLASS					
1.00	INTEREST EXPENSE	113.00	0	692,271	9	1.00
2.00		0.00	0	0	9	2.00
	TOTALS		0	692,271		
	L - RECLASS RHC ADMIN SALARIES TO ADMIN					
1.00	RHC - CARLINVILLE	88.00	142,450	0	0	1.00
2.00	RHC - GIRARD	88.01	44,229	0	0	2.00
	TOTALS		186,679	0		
500.00	Grand Total: Decreases		186,679	766,424		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet A-7
Part I
Date/Time Prepared:
12/21/2018 2:20 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	517,171	0	0	0	16,999	1.00
2.00	Land Improvements	2,364,575	68,221	0	68,221	0	2.00
3.00	Buildings and Fixtures	25,861,660	0	0	0	1,896	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,652,905	249,030	0	249,030	0	6.00
7.00	HIT designated Assets	1,180,327	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,576,638	317,251	0	317,251	18,895	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,576,638	317,251	0	317,251	18,895	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	500,172	0				1.00
2.00	Land Improvements	2,432,796	0				2.00
3.00	Buildings and Fixtures	25,859,764	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	6,901,935	0				6.00
7.00	HIT designated Assets	1,180,327	0				7.00
8.00	Subtotal (sum of lines 1-7)	36,874,994	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	36,874,994	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet A-7
Part II
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,674,507	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	481,283	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,155,790	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,674,507				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	481,283				2.00
3.00	Total (sum of lines 1-2)	0	2,155,790				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet A-7
Part III
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	28,792,733	0	28,792,733	0.780820	57,900	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,082,261	0	8,082,261	0.219180	16,253	2.00
3.00	Total (sum of lines 1-2)	36,874,994	0	36,874,994	1.000000	74,153	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	57,900	2,202,758	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	16,253	479,733	0	2.00
3.00	Total (sum of lines 1-2)	0	0	74,153	2,682,491	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	57,900	0	0	2,260,658	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	16,253	0	0	495,986	2.00
3.00	Total (sum of lines 1-2)	0	74,153	0	0	2,756,644	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			Ref.
			Cost Center	Line #	wkst. A-7	
			1.00	2.00	3.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-27,214	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	-2,100	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	-2,459	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	-1,694,062			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	-71,389	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	-46,307	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-7,794	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	-1,616	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	B	-785	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	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

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
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-1,550	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9 32.00
33.00 DIETARY DISCOUNTS	B	-1,325	DIETARY	10.00	0 33.00
33.01 RADIOLOGY DISCOUNTS	B	-26,790	RADIOLOGY-DIAGNOSTIC	54.00	0 33.01
33.02 PT PROF FEES	B	-500	PHYSICAL THERAPY	66.00	0 33.02
33.03 PREVIOUS DEBT ISSUANCE COSTS	A	43,119	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 33.03
33.04 CONTRACT LAB	B	-300	LABORATORY	60.00	0 33.04
33.05 SUPPLIES	B	-3,477	OPERATING ROOM	50.00	0 33.05
33.06 AHA & IHA DUES	A	-9,776	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 PLANT OPERATION DISCOUNTS	B	-110	OPERATION OF PLANT	7.00	0 33.07
36.00 ACQUATIC THERAPY	B	-7,945	PHYSICAL THERAPY	66.00	0 36.00
37.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 37.00
39.00 MED STAFF RELATIONS	A	-9,356	ADMINISTRATIVE & GENERAL	5.00	0 39.00
40.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 40.00
41.00 NON-PATIENT REVENUE	B	-428	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00 ADVERTISING	A	-159,494	ADMINISTRATIVE & GENERAL	5.00	0 42.00
44.00 TELEPHONE DEPRECIATION	A	-2,406	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 44.00
44.01 TELEPHONE TRUNKLINE CHARGES	A	-3,325	ADMINISTRATIVE & GENERAL	5.00	0 44.01
44.02 SPRINGFIELD CLINIC RENT	B	-42,885	CLINIC	90.00	0 44.02
44.03 PATIENT TELEVISION OFFSET	A	-2,655	ADMINISTRATIVE & GENERAL	5.00	0 44.03
44.04 INSURANCE PROCEEDS	A	-1,565	ADMINISTRATIVE & GENERAL	5.00	0 44.04
44.05 MOB BUILDING RENT	B	-176,598	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 44.05
44.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 44.06
44.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 44.07
45.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.00
45.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.01
45.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.02
45.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.03
45.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.04
45.05 EKG PROFESSIONAL FEES	A	-46,150	ELECTROCARDIOLOGY	69.00	0 45.05
45.06 SLEEP STUDY PROFESSIONAL FEES	A	0	RESPIRATORY THERAPY	65.00	0 45.06
45.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.07
45.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.08
45.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,307,242			50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet A-8-2

Date/Time Prepared:
12/21/2018 2:20 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,588,759	986,937	601,822	0	0	1.00
2.00	91.00	EMERGENCY	392,803	392,803	0	0	0	2.00
3.00	50.00	OPERATING ROOM	262,069	262,069	0	0	0	3.00
4.00	91.00	EMERGENCY	52,253	52,253	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,295,884	1,694,062	601,822	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	986,937		1.00
2.00	91.00	EMERGENCY	0	0	0	392,803		2.00
3.00	50.00	OPERATING ROOM	0	0	0	262,069		3.00
4.00	91.00	EMERGENCY	0	0	0	52,253		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	1,694,062		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/21/2018 2:20 pm
		Respiratory Therapy	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					0.55	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,378.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	64.04	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.02	32.02	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
		1.00					
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					88,247	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					88,247	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)					88,247	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					88,247	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1347		Period: From 08/01/2017 To 07/31/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/21/2018 2:20 pm	
		Respiratory Therapy				Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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	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)	64.04	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)					88,247	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)					88,247	63.00
64.00	Total cost of outside supplier services (from your records)					89,863	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					1,616	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/21/2018 2:20 pm
		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					0.55	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	310.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.27	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)	37.14	37.14	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)					23,042	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					23,042	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)					23,042	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)					74.27	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					57,931	22.00
23.00	Total salary equivalency (see instructions)					57,931	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: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/21/2018 2:20 pm
		Speech Pathology	Cost

46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					1.00	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	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	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)	74.27	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)	57,931	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)	57,931	63.00
64.00	Total cost of outside supplier services (from your records)	18,616	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02

LINE 34 CALCULATION

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02

LINE 35 CALCULATION

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet B
Part I
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,260,658	2,260,658			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	495,986		495,986		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,095,495	0	0	2,095,495	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,961,734	487,524	162,652	322,921	4,934,831 5.00
7.00 00700	OPERATION OF PLANT	695,264	261,407	24,438	45,722	1,026,831 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	178,642	0	0	0	178,642 8.00
9.00 00900	HOUSEKEEPING	318,653	10,684	19	58,607	387,963 9.00
10.00 01000	DIETARY	331,688	41,133	18,211	37,622	428,654 10.00
11.00 01100	CAFETERIA	0	41,448	0	0	41,448 11.00
13.00 01300	NURSING ADMINISTRATION	341,028	6,789	680	67,773	416,270 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	220,184	30,621	5,076	32,727	288,608 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	190,845	2,263	9,661	38,788	241,557 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,159,217	321,044	43,022	189,628	1,712,911 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	748,097	150,669	58,021	68,936	1,025,723 50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,408,985	101,171	19,212	96,876	1,626,244 54.00
60.00 06000	LABORATORY	1,335,194	42,193	24,252	122,980	1,524,619 60.00
65.00 06500	RESPIRATORY THERAPY	592,010	91,547	29,044	74,101	786,702 65.00
66.00 06600	PHYSICAL THERAPY	968,015	186,961	33,367	188,152	1,376,495 66.00
67.00 06700	OCCUPATIONAL THERAPY	227,411	14,179	0	46,417	288,007 67.00
69.00 06900	ELECTROCARDIOLOGY	147,931	87,279	0	19,212	254,422 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	258,643	23,689	1,080	18,483	301,895 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	42,226	0	0	0	42,226 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,002,021	18,447	6,013	46,171	1,072,652 73.00
76.00 03550	BEHAVIORAL HEALTH	255,686	37,753	1,022	30,993	325,454 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC - CARLINVILLE	1,430,585	169,087	30,205	250,491	1,880,368 88.00
88.01 08801	RHC - GIRARD	249,304	0	0	41,634	290,938 88.01
90.00 09000	CLINIC	338,586	64,535	3,043	47,291	453,455 90.00
91.00 09100	EMERGENCY	1,456,683	63,246	26,627	247,345	1,793,901 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					
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	22,710,771	2,253,669	495,645	2,092,870	22,700,816 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,242	21	0	5,263 190.00
194.00 07950	NONREIMBURSABLE COSTS CENTERS	181,013	0	0	0	181,013 194.00
194.01 07951	FUND DEVELOPMENT	13,060	1,747	320	2,625	17,752 194.01
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	22,904,844	2,260,658	495,986	2,095,495	22,904,844 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,934,831					5.00
7.00	00700	281,983	1,308,814				7.00
8.00	00800	49,058	0	227,700			8.00
9.00	00900	106,540	9,250	0	503,753		9.00
10.00	01000	117,715	35,612	0	13,119	595,100	10.00
11.00	01100	11,382	35,885	0	13,219	357,130	11.00
13.00	01300	114,314	5,877	0	2,165	0	13.00
16.00	01600	79,256	26,511	0	9,766	0	16.00
19.00	01900	66,335	1,959	0	722	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	470,391	277,950	107,120	102,393	237,970	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	281,679	130,445	18,929	48,054	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	446,591	87,592	20,916	32,267	0	54.00
60.00	06000	418,683	36,530	0	13,457	0	60.00
65.00	06500	216,040	79,259	1,592	29,198	0	65.00
66.00	06600	378,006	161,866	18,650	59,629	0	66.00
67.00	06700	79,091	12,276	0	4,522	0	67.00
69.00	06900	69,868	75,564	0	27,837	0	69.00
71.00	07100	82,905	20,509	0	7,555	0	71.00
72.00	07200	11,596	0	0	0	0	72.00
73.00	07300	294,566	15,971	0	5,883	0	73.00
76.00	03550	89,375	32,686	0	12,041	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	516,374	146,391	129	53,928	0	88.00
88.01	08801	79,896	0	0	25,014	0	88.01
90.00	09000	124,526	55,873	0	20,583	0	90.00
91.00	09100	492,632	54,757	60,364	20,172	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		4,878,802	1,302,763	227,700	501,524	595,100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,445	4,538	0	1,672	0	190.00
194.00	07950	49,709	0	0	0	0	194.00
194.01	07951	4,875	1,513	0	557	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,934,831	1,308,814	227,700	503,753	595,100	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		11.00	13.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	459,064					11.00
13.00	01300	13,786	552,412				13.00
16.00	01600	26,652	0	430,793			16.00
19.00	01900	9,190	23,113	6,167	349,043		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	102,014	256,560	23,424	0	3,290,733	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	21,598	54,317	25,987	0	1,606,732	50.00
53.00	05300	0	0	0	349,043	349,043	53.00
54.00	05400	32,626	0	112,624	0	2,358,860	54.00
60.00	06000	42,506	0	84,704	0	2,120,499	60.00
65.00	06500	21,138	0	12,022	0	1,145,951	65.00
66.00	06600	60,427	0	41,301	0	2,096,374	66.00
67.00	06700	13,786	0	7,101	0	404,783	67.00
69.00	06900	6,893	0	9,575	0	444,159	69.00
71.00	07100	7,812	0	9,460	0	430,136	71.00
72.00	07200	0	0	672	0	54,494	72.00
73.00	07300	13,786	34,670	27,728	0	1,465,256	73.00
76.00	03550	13,786	34,670	5,310	0	513,322	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	14,210	0	2,611,400	88.00
88.01	08801	0	0	2,381	0	398,229	88.01
90.00	09000	13,786	34,670	3,906	0	706,799	90.00
91.00	09100	54,683	114,412	44,221	0	2,635,142	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0		0	116.00
118.00		454,469	552,412	430,793	349,043	22,631,912	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	12,918	190.00
194.00	07950	0	0	0	0	230,722	194.00
194.01	07951	4,595	0	0	0	29,292	194.01
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		459,064	552,412	430,793	349,043	22,904,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

worksheet B
Part I
Date/Time Prepared:
12/21/2018 2:20 pm

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	3,290,733
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,606,732
53.00	05300	ANESTHESIOLOGY	0	349,043
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,358,860
60.00	06000	LABORATORY	0	2,120,499
65.00	06500	RESPIRATORY THERAPY	0	1,145,951
66.00	06600	PHYSICAL THERAPY	0	2,096,374
67.00	06700	OCCUPATIONAL THERAPY	0	404,783
69.00	06900	ELECTROCARDIOLOGY	0	444,159
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	430,136
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	54,494
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,465,256
76.00	03550	BEHAVIORIAL HEALTH	0	513,322
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	2,611,400
88.01	08801	RHC - GIRARD	0	398,229
90.00	09000	CLINIC	0	706,799
91.00	09100	EMERGENCY	0	2,635,142
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		
116.00	11600	HOSPICE	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	22,631,912
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,918
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	230,722
194.01	07951	FUND DEVELOPMENT	0	29,292
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	22,904,844

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet B
Part II
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	41,239	487,524	162,652	691,415	5.00
7.00 00700	OPERATION OF PLANT	0	261,407	24,438	285,845	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	10,684	19	10,703	9.00
10.00 01000	DIETARY	1,673	41,133	18,211	61,017	10.00
11.00 01100	CAFETERIA	0	41,448	0	41,448	11.00
13.00 01300	NURSING ADMINISTRATION	0	6,789	680	7,469	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	30,621	5,076	35,697	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	2,263	9,661	11,924	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,144	321,044	43,022	374,210	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	292,333	150,669	58,021	501,023	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	154,874	101,171	19,212	275,257	54.00
60.00 06000	LABORATORY	20,681	42,193	24,252	87,126	60.00
65.00 06500	RESPIRATORY THERAPY	18,846	91,547	29,044	139,437	65.00
66.00 06600	PHYSICAL THERAPY	0	186,961	33,367	220,328	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	14,179	0	14,179	67.00
69.00 06900	ELECTROCARDIOLOGY	0	87,279	0	87,279	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,689	1,080	24,769	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	87,080	18,447	6,013	111,540	73.00
76.00 03550	BEHAVIORIAL HEALTH	0	37,753	1,022	38,775	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC - CARLINVILLE	0	169,087	30,205	199,292	88.00
88.01 08801	RHC - GIRARD	26,377	0	0	26,377	88.01
90.00 09000	CLINIC	0	64,535	3,043	67,578	90.00
91.00 09100	EMERGENCY	0	63,246	26,627	89,873	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	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	653,247	2,253,669	495,645	3,402,561	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,242	21	5,263	190.00
194.00 07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	194.00
194.01 07951	FUND DEVELOPMENT	0	1,747	320	2,067	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	653,247	2,260,658	495,986	3,409,891	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet B
Part II
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12/21/2018 2:20 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	691,415					5.00
7.00	00700	39,508	325,353				7.00
8.00	00800	6,873		6,873			8.00
9.00	00900	14,927	2,299				9.00
10.00	01000	16,493	8,853		27,929		10.00
11.00	01100	1,595	8,920		727	87,090	11.00
13.00	01300	16,016	1,461		0	52,264	13.00
16.00	01600	11,104	6,590		120	0	16.00
19.00	01900	9,294	487		541	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	65,906	69,095	3,234	5,677	34,826	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	39,466	32,427	571	2,664	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	62,571	21,774	631	1,789	0	54.00
60.00	06000	58,661	9,081	0	746	0	60.00
65.00	06500	30,269	19,703	48	1,619	0	65.00
66.00	06600	52,962	40,238	563	3,306	0	66.00
67.00	06700	11,081	3,052	0	251	0	67.00
69.00	06900	9,789	18,784	0	1,543	0	69.00
71.00	07100	11,616	5,098	0	419	0	71.00
72.00	07200	1,625	0	0	0	0	72.00
73.00	07300	41,271	3,970	0	326	0	73.00
76.00	03550	12,522	8,125	0	668	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	72,353	36,391	4	2,990	0	88.00
88.01	08801	11,194	0	0	1,387	0	88.01
90.00	09000	17,447	13,889	0	1,141	0	90.00
91.00	09100	69,022	13,612	1,822	1,118	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		683,565	323,849	6,873	27,805	87,090	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	202	1,128	0	93	0	190.00
194.00	07950	6,965	0	0	0	0	194.00
194.01	07951	683	376	0	31	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		691,415	325,353	6,873	27,929	87,090	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet B
Part II
Date/Time Prepared:
12/21/2018 2:20 pm

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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	104,960					11.00
13.00	01300	3,152	28,218				13.00
16.00	01600	6,094	0	60,026			16.00
19.00	01900	2,101	1,181	859	25,886		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	23,323	13,105	3,264		592,640	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,938	2,775	3,622		587,486	50.00
53.00	05300	0	0	0		0	53.00
54.00	05400	7,460	0	15,686		385,168	54.00
60.00	06000	9,719	0	11,805		177,138	60.00
65.00	06500	4,833	0	1,675		197,584	65.00
66.00	06600	13,816	0	5,756		336,969	66.00
67.00	06700	3,152	0	990		32,705	67.00
69.00	06900	1,576	0	1,334		120,305	69.00
71.00	07100	1,786	0	1,318		45,006	71.00
72.00	07200	0	0	94		1,719	72.00
73.00	07300	3,152	1,771	3,864		165,894	73.00
76.00	03550	3,152	1,771	740		65,753	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	1,980		313,010	88.00
88.01	08801	0	0	332		39,290	88.01
90.00	09000	3,152	1,771	544		105,522	90.00
91.00	09100	12,503	5,844	6,163		199,957	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0		0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0		0	116.00
118.00		103,909	28,218	60,026	0	3,366,146	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0		6,686	190.00
194.00	07950	0	0	0		6,965	194.00
194.01	07951	1,051	0	0		4,208	194.01
200.00					25,886	25,886	200.00
201.00		0	0	0	0	0	201.00
202.00		104,960	28,218	60,026	25,886	3,409,891	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet B
Part II
Date/Time Prepared:
12/21/2018 2:20 pm

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	592,640
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	587,486
53.00	05300	ANESTHESIOLOGY	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	385,168
60.00	06000	LABORATORY	0	177,138
65.00	06500	RESPIRATORY THERAPY	0	197,584
66.00	06600	PHYSICAL THERAPY	0	336,969
67.00	06700	OCCUPATIONAL THERAPY	0	32,705
69.00	06900	ELECTROCARDIOLOGY	0	120,305
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,006
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,719
73.00	07300	DRUGS CHARGED TO PATIENTS	0	165,894
76.00	03550	BEHAVIORIAL HEALTH	0	65,753
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	313,010
88.01	08801	RHC - GIRARD	0	39,290
90.00	09000	CLINIC	0	105,522
91.00	09100	EMERGENCY	0	199,957
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,366,146
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	6,686
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	6,965
194.01	07951	FUND DEVELOPMENT	0	4,208
200.00		Cross Foot Adjustments	0	25,886
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	3,409,891

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	78,922					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		434,932				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,001,055			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	17,020	142,630	1,541,163	-4,934,831	17,970,013	5.00
7.00 00700	OPERATION OF PLANT	9,126	21,430	218,214	0	1,026,831	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	178,642	8.00
9.00 00900	HOUSEKEEPING	373	17	279,709	0	387,963	9.00
10.00 01000	DIETARY	1,436	15,969	179,555	0	428,654	10.00
11.00 01100	CAFETERIA	1,447	0	0	0	41,448	11.00
13.00 01300	NURSING ADMINISTRATION	237	596	323,455	0	416,270	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,069	4,451	156,196	0	288,608	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	79	8,472	185,122	0	241,557	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	11,208	37,726	905,031	0	1,712,911	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	5,260	50,879	329,009	0	1,025,723	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,532	16,847	462,356	0	1,626,244	54.00
60.00 06000	LABORATORY	1,473	21,267	586,942	0	1,524,619	60.00
65.00 06500	RESPIRATORY THERAPY	3,196	25,469	353,660	0	786,702	65.00
66.00 06600	PHYSICAL THERAPY	6,527	29,260	897,986	0	1,376,495	66.00
67.00 06700	OCCUPATIONAL THERAPY	495	0	221,534	0	288,007	67.00
69.00 06900	ELECTROCARDIOLOGY	3,047	0	91,690	0	254,422	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	947	88,215	0	301,895	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	42,226	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	644	5,273	220,358	0	1,072,652	73.00
76.00 03550	BEHAVIORIAL HEALTH	1,318	896	147,921	0	325,454	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RHC - CARLINVILLE	5,903	26,487	1,195,505	0	1,880,368	88.00
88.01 08801	RHC - GIRARD	0	0	198,707	0	290,938	88.01
90.00 09000	CLINIC	2,253	2,668	225,705	0	453,455	90.00
91.00 09100	EMERGENCY	2,208	23,349	1,180,494	0	1,793,901	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	78,678	434,633	9,988,527	-4,934,831	17,765,985	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	5,263	190.00
194.00 07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	181,013	194.00
194.01 07951	FUND DEVELOPMENT	61	281	12,528	0	17,752	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)	2,260,658	495,986	2,095,495		4,934,831	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	28.644206	1.140376	0.209527		0.274615	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		691,415	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.038476	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet B-1
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		OPERATION OF PLANT (SQURE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQURE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	52,776					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	118,293				8.00
9.00	00900 HOUSEKEEPING	373	0	55,141			9.00
10.00	01000 DIETARY	1,436	0	1,436	32,497		10.00
11.00	01100 CAFETERIA	1,447	0	1,447	19,502	9,990	11.00
13.00	01300 NURSING ADMINISTRATION	237	0	237	0	300	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,069	0	1,069	0	580	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	79	0	79	0	200	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	11,208	55,650	11,208	12,995	2,220	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,260	9,834	5,260	0	470	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,532	10,866	3,532	0	710	54.00
60.00	06000 LABORATORY	1,473	0	1,473	0	925	60.00
65.00	06500 RESPIRATORY THERAPY	3,196	827	3,196	0	460	65.00
66.00	06600 PHYSICAL THERAPY	6,527	9,689	6,527	0	1,315	66.00
67.00	06700 OCCUPATIONAL THERAPY	495	0	495	0	300	67.00
69.00	06900 ELECTROCARDIOLOGY	3,047	0	3,047	0	150	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	827	0	827	0	170	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	300	73.00
76.00	03550 BEHAVIORIAL HEALTH	1,318	0	1,318	0	300	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	5,903	67	5,903	0	0	88.00
88.01	08801 RHC - GIRARD	0	0	2,738	0	0	88.01
90.00	09000 CLINIC	2,253	0	2,253	0	300	90.00
91.00	09100 EMERGENCY	2,208	31,360	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 through 117)	52,532	118,293	54,897	32,497	9,890	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	0	183	0	0	190.00
194.00	07950 NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951 FUND DEVELOPMENT	61	0	61	0	100	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,308,814	227,700	503,753	595,100	459,064	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	24.799416	1.924881	9.135725	18.312460	45.952352	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	325,353	6,873	27,929	87,090	104,960	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	6.164791	0.058101	0.506502	2.679940	10.506507	205.00
206.00	NAHE adjustment amount to be allocated (per wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (wkst. D, Parts III and IV)						207.00

Cost 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	99,424		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,731,199	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,160	697,592	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	46,176	2,649,754	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,776	2,939,701	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,739,189	54.00
60.00	06000	LABORATORY	0	9,581,908	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,359,915	65.00
66.00	06600	PHYSICAL THERAPY	0	4,672,074	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	803,311	67.00
69.00	06900	ELECTROCARDIOLOGY	0	1,083,176	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,070,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	76,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,240	3,136,678	73.00
76.00	03550	BEHAVIORIAL HEALTH	6,240	600,727	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	1,607,419	88.00
88.01	08801	RHC - GIRARD	0	269,393	88.01
90.00	09000	CLINIC	6,240	441,830	90.00
91.00	09100	EMERGENCY	20,592	5,002,374	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			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,424	48,731,199	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	194.00
194.01	07951	FUND DEVELOPMENT	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)	552,412	430,793	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	5.556123	0.008840	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	28,218	60,026	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.283815	0.001232	205.00
206.00		NAHE adjustment amount to be allocated (per wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet C
Part I
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3,290,733		3,290,733	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,606,732		1,606,732	0	50.00
53.00	05300 ANESTHESIOLOGY	349,043		349,043	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,358,860		2,358,860	0	54.00
60.00	06000 LABORATORY	2,120,499		2,120,499	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,145,951	0	1,145,951	0	65.00
66.00	06600 PHYSICAL THERAPY	2,096,374	0	2,096,374	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	404,783	0	404,783	0	67.00
69.00	06900 ELECTROCARDIOLOGY	444,159		444,159	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	430,136		430,136	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	54,494		54,494	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,465,256		1,465,256	0	73.00
76.00	03550 BEHAVIORIAL HEALTH	513,322		513,322	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - CARLINVILLE	2,611,400		2,611,400	0	88.00
88.01	08801 RHC - GIRARD	398,229		398,229	0	88.01
90.00	09000 CLINIC	706,799		706,799	0	90.00
91.00	09100 EMERGENCY	2,635,142		2,635,142	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	452,816		452,816	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0		0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	0		0		116.00
200.00	Subtotal (see instructions)	23,084,728	0	23,084,728	0	200.00
201.00	Less Observation Beds	452,816		452,816		201.00
202.00	Total (see instructions)	22,631,912	0	22,631,912	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet C
Part I
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		Charges			Hospital	Cost	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)				Cost or Other Ratio
		6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,896,300		1,896,300			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	47,243	2,892,458	2,939,701	0.546563	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	9,654	687,938	697,592	0.500354	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	653,946	12,085,243	12,739,189	0.185166	0.000000	54.00
60.00	06000	LABORATORY	958,389	8,623,519	9,581,908	0.221302	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	543,965	815,950	1,359,915	0.842664	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	509,536	4,162,538	4,672,074	0.448703	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	384,855	418,456	803,311	0.503893	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	43,352	1,039,824	1,083,176	0.410052	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	479,427	590,719	1,070,146	0.401941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	76,012	76,012	0.716913	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,345,775	1,790,903	3,136,678	0.467136	0.000000	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	600,727	600,727	0.854501	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0	1,607,419	1,607,419			88.00
88.01	08801	RHC - GIRARD	0	269,393	269,393			88.01
90.00	09000	CLINIC	8,816	433,014	441,830	1.599708	0.000000	90.00
91.00	09100	EMERGENCY	156,050	4,846,324	5,002,374	0.526778	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,664	713,790	753,454	0.600987	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	7,076,972	41,654,227	48,731,199			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,076,972	41,654,227	48,731,199			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet C
Part I
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 BEHAVIORIAL HEALTH	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - CARLINVILLE				88.00
88.01	08801 RHC - GIRARD				88.01
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet D Part II Date/Time Prepared: 12/21/2018 2:20 pm
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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	587,486	2,939,701	0.199845	32,682	6,531	50.00
53.00	05300 ANESTHESIOLOGY	0	697,592	0.000000	4,070	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	385,168	12,739,189	0.030235	376,848	11,394	54.00
60.00	06000 LABORATORY	177,138	9,581,908	0.018487	484,327	8,954	60.00
65.00	06500 RESPIRATORY THERAPY	197,584	1,359,915	0.145291	286,981	41,696	65.00
66.00	06600 PHYSICAL THERAPY	336,969	4,672,074	0.072124	64,626	4,661	66.00
67.00	06700 OCCUPATIONAL THERAPY	32,705	803,311	0.040713	28,726	1,170	67.00
69.00	06900 ELECTROCARDIOLOGY	120,305	1,083,176	0.111067	27,324	3,035	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45,006	1,070,146	0.042056	211,047	8,876	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,719	76,012	0.022615	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	165,894	3,136,678	0.052888	605,831	32,041	73.00
76.00	03550 BEHAVIORIAL HEALTH	65,753	600,727	0.109456	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC - CARLINVILLE	313,010	1,607,419	0.194728	0	0	88.00
88.01	08801 RHC - GIRARD	39,290	269,393	0.145846	0	0	88.01
90.00	09000 CLINIC	105,522	441,830	0.238829	5,491	1,311	90.00
91.00	09100 EMERGENCY	199,957	5,002,374	0.039972	16,363	654	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	81,549	753,454	0.108234	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	2,855,055	46,834,899		2,144,316	120,323	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet D Part IV Date/Time Prepared: 12/21/2018 2:20 pm
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Cost Center Description	Title XVIII				Hospital		Allied Health Cost	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	349,043	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	349,043	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet D Part IV Date/Time Prepared: 12/21/2018 2:20 pm
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Cost Center Description		Title XVIII			Hospital	Cost		
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,939,701	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	349,043	0	697,592	0.500354	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,739,189	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,581,908	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,359,915	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,672,074	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	803,311	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,083,176	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,070,146	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	76,012	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,136,678	0.000000	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	0	600,727	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0	0	0	1,607,419	0.000000	88.00
88.01	08801	RHC - GIRARD	0	0	0	269,393	0.000000	88.01
90.00	09000	CLINIC	0	0	0	441,830	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,002,374	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	753,454	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	349,043	0	46,834,899		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet D
Part IV
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	32,682	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,070	2,036	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	376,848	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	484,327	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	286,981	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	64,626	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	28,726	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	27,324	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	211,047	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	605,831	0	0	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0.000000	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	5,491	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	16,363	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,144,316	2,036	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet D Part V Date/Time Prepared: 12/21/2018 2:20 pm
Title XVIII		Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.546563	0	1,210,930	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.500354	0	302,159	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185166	0	4,855,401	0	0	54.00
60.00	06000	LABORATORY	0.221302	0	3,673,069	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.842664	0	376,639	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.448703	0	1,517,987	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503893	0	118,809	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.410052	0	504,131	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.401941	0	221,244	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.716913	0	50,756	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.467136	0	1,026,246	4,009	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0.854501	0	600,727	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC - CARLINVILLE	0.000000				0	88.00
88.01	08801	RHC - GIRARD	0.000000				0	88.01
90.00	09000	CLINIC	1.599708	0	149,472	0	0	90.00
91.00	09100	EMERGENCY	0.526778	0	1,699,902	423	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.600987	0	394,486	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	16,701,958	4,432	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	16,701,958	4,432	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN:14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet D Part V Date/Time Prepared: 12/21/2018 2:20 pm
Title XVIII		Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	661,850	0		50.00
53.00 05300 ANESTHESIOLOGY	151,186	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	899,055	0		54.00
60.00 06000 LABORATORY	812,858	0		60.00
65.00 06500 RESPIRATORY THERAPY	317,380	0		65.00
66.00 06600 PHYSICAL THERAPY	681,125	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	59,867	0		67.00
69.00 06900 ELECTROCARDIOLOGY	206,720	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	88,927	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	36,388	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	479,396	1,873		73.00
76.00 03550 BEHAVIORIAL HEALTH	513,322	0		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RHC - CARLINVILLE	0	0		88.00
88.01 08801 RHC - GIRARD	0	0		88.01
90.00 09000 CLINIC	239,112	0		90.00
91.00 09100 EMERGENCY	895,471	223		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	237,081	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	6,279,738	2,096		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 - line 201)	6,279,738	2,096		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1347 Component CCN: 14-2347	Period: From 08/01/2017 To 07/31/2018	Worksheet D Part V Date/Time Prepared: 12/21/2018 2:20 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.546563	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.500354	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.185166	0	0	0	54.00
60.00	06000 LABORATORY	0.221302	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.842664	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.448703	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.503893	0	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.410052	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.401941	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.716913	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.467136	0	0	0	73.00
76.00	03550 BEHAVIORIAL HEALTH	0.854501	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC - CARLINVILLE	0.000000				88.00
88.01	08801 RHC - GIRARD	0.000000				88.01
90.00	09000 CLINIC	1.599708	0	0	0	90.00
91.00	09100 EMERGENCY	0.526778	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.600987	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	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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet D
Part V
Date/Time Prepared:
12/21/2018 2:20 pm

Component CCN: 14-Z347

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs		Swing Beds - SNF	Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03550	BEHAVIORIAL HEALTH	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	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	0	95.00
200.00		Subtotal (see instructions)	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	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet D-1

Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		Title XVIII	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,103 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,663 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)			1,246 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			660 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)			695 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			23 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)			62 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			909 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)			554 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)			587 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			155.41 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			160.07 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,290,733 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)			3,574 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)			9,924 25.00
26.00	Total swing-bed cost (see instructions)			1,484,893 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,805,840 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)			1,805,840 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)			1,085.90 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			987,083 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)			987,083 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet D-1

Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description	Title XVIII			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					878,604
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,865,687
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					601,589
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					637,423
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,239,012
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					417
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,085.89
89.00 Observation bed cost (line 87 x line 88) (see instructions)					452,816

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet D-1

Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description	Title XVIII			Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Cost	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	592,640	3,290,733	0.180094	452,816	81,549	90.00
91.00 Nursing School cost	0	3,290,733	0.000000	452,816	0	91.00
92.00 Allied health cost	0	3,290,733	0.000000	452,816	0	92.00
93.00 All other Medical Education	0	3,290,733	0.000000	452,816	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet D-3

Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		854,498		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.546563	32,682	17,863	50.00
53.00	05300 ANESTHESIOLOGY	0.500354	4,070	2,036	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.185166	376,848	69,779	54.00
60.00	06000 LABORATORY	0.221302	484,327	107,183	60.00
65.00	06500 RESPIRATORY THERAPY	0.842664	286,981	241,829	65.00
66.00	06600 PHYSICAL THERAPY	0.448703	64,626	28,998	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.503893	28,726	14,475	67.00
69.00	06900 ELECTROCARDIOLOGY	0.410052	27,324	11,204	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.401941	211,047	84,828	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.716913	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.467136	605,831	283,005	73.00
76.00	03550 BEHAVIORIAL HEALTH	0.854501	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - CARLINVILLE	0.000000		0	88.00
88.01	08801 RHC - GIRARD	0.000000		0	88.01
90.00	09000 CLINIC	1.599708	5,491	8,784	90.00
91.00	09100 EMERGENCY	0.526778	16,363	8,620	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.600987	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,144,316	878,604	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,144,316		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1347
Component CCN: 14-2347

Period:
From 08/01/2017
To 07/31/2018

Worksheet D-3
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.546563	3,028	1,655	50.00
53.00	05300 ANESTHESIOLOGY	0.500354	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.185166	102,313	18,945	54.00
60.00	06000 LABORATORY	0.221302	244,518	54,112	60.00
65.00	06500 RESPIRATORY THERAPY	0.842664	167,280	140,961	65.00
66.00	06600 PHYSICAL THERAPY	0.448703	333,104	149,465	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.503893	270,451	136,278	67.00
69.00	06900 ELECTROCARDIOLOGY	0.410052	3,864	1,584	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.401941	157,443	63,283	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.716913	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.467136	409,356	191,225	73.00
76.00	03550 BEHAVIORIAL HEALTH	0.854501	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RHC - CARLINVILLE	0.000000		0	88.00
88.01	08801 RHC - GIRARD	0.000000		0	88.01
90.00	09000 CLINIC	1.599708	3,028	4,844	90.00
91.00	09100 EMERGENCY	0.526778	6,820	3,593	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.600987	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,701,205	765,945	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)		1,701,205		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet E
Part B
Date/Time Prepared:
12/21/2018 2:20 pm

		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			6,281,834	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)			0	2.00
3.00	OPPI payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,281,834	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			6,344,652	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			53,133	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,582,664	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)			3,708,855	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)			3,708,855	30.00
31.00	Primary payer payments			299	31.00
32.00	Subtotal (line 30 minus line 31)			3,708,556	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)			372,628	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			242,208	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			372,628	36.00
37.00	Subtotal (see instructions)			3,950,764	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			3,950,764	40.00
40.01	Sequestration adjustment (see instructions)			79,015	40.01
40.02	Demonstration payment adjustment amount after sequestration			0	40.02
41.00	Interim payments			4,312,635	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			-440,886	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet E-1
Part I
Date/Time Prepared:
12/21/2018 2:20 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,364,733		4,129,021	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02		07/31/2018	38,430	07/31/2018	202,302	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	03/08/2018	18,688	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)		38,430		183,614	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)		1,403,163		4,312,635	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		148,359		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		440,886	6.02
7.00	Total Medicare program liability (see instructions)		1,551,522		3,871,749	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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

Period:
From 08/01/2017
To 07/31/2018

Worksheet E-1
Part I
Date/Time Prepared:
12/21/2018 2:20 pm

		Inpatient Part A		Part B		Cost
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,817,357		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	03/08/2018	41,759		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)		-41,759		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,775,598		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		184,429		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,960,027		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet E-1 Part II Date/Time Prepared: 12/21/2018 2:20 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet E-2

Component CCN: 14-Z347

Date/Time Prepared:
12/21/2018 2:20 pm

		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)	1,251,402	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)	773,604	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	1,141	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)	2,025,006	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,025,006	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)	2,025,006	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	24,978	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)	2,000,028	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,000,028	0	19.00
19.01	Sequestration adjustment (see instructions)	40,001	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,775,598	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)	184,429	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

worksheet E-3
Part V
Date/Time Prepared:
12/21/2018 2:20 pm

		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,865,687 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)			1,865,687 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,884,344 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)			1,884,344 19.00
20.00	Deductibles (exclude professional component)			301,158 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,583,186 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,583,186 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			0 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,583,186 28.00
29.00	-14011			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			1,583,186 30.00
30.01	Sequestration adjustment (see instructions)			31,664 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			1,403,163 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			148,359 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

Health Financial Systems

CARLINVILLE AREA HOSPITAL

In Lieu of Form CMS-2552-10

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

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

worksheet G

Date/Time Prepared:
12/21/2018 2:20 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,549,549	0	0	0	1.00
2.00	Temporary investments	1,128,970	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,554,260	0	0	0	4.00
5.00	Other receivable	113,835	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-646,000	0	0	0	6.00
7.00	Inventory	250,853	0	0	0	7.00
8.00	Prepaid expenses	253,733	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)	9,205,200	0	0	0	11.00
FIXED ASSETS						
12.00	Land	500,172	0	0	0	12.00
13.00	Land improvements	2,432,796	0	0	0	13.00
14.00	Accumulated depreciation	-802,662	0	0	0	14.00
15.00	Buildings	25,859,764	0	0	0	15.00
16.00	Accumulated depreciation	-10,076,662	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	6,901,935	0	0	0	23.00
24.00	Accumulated depreciation	-5,227,796	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	-934,317	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,833,557	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,215,415	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,215,415	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,254,172	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	852,917	0	0	0	37.00
38.00	Salaries, wages, and fees payable	874,820	0	0	0	38.00
39.00	Payroll taxes payable	35,638	0	0	0	39.00
40.00	Notes and loans payable (short term)	903,083	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	260,717	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,927,175	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,586,947	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,586,947	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,514,122	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	16,740,050				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	16,740,050	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,254,172	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet G-1

Date/Time Prepared:
12/21/2018 2:20 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,444,371			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		320,638				2.00
3.00	Total (sum of line 1 and line 2)		16,765,009			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		16,765,009			0	11.00
12.00	DECREASE IN PERM RESTRICTED	24,959		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)		24,959			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,740,050			0	19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	DECREASE IN PERM RESTRICTED		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
12/21/2018 2:20 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,995,330		1,995,330	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	699,200		699,200	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,694,530		2,694,530	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,694,530		2,694,530	17.00
18.00	Ancillary services	4,953,023	0	4,953,023	18.00
19.00	Outpatient services	0	42,069,687	42,069,687	19.00
20.00	RHC - CARLINVILLE	0	1,607,419	1,607,419	20.00
20.01	RHC - GIRARD	0	470,465	470,465	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)	7,647,553	44,147,571	51,795,124	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		25,212,086		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	MISC	214			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)		214		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		25,211,872		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet G-3

Date/Time Prepared:
12/21/2018 2:20 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,795,124	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,973,870	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,821,254	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,211,872	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-390,618	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	65,664	6.00
7.00	Income from investments	118,192	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	35,791	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	71,389	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	219,483	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	20,016	24.01
24.02	PHYSICAL THERAPY - NON PATIENTS	0	24.02
24.03	OTHER	120,398	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	14,150	24.05
24.06	GRANTS	46,173	24.06
25.00	Total other income (sum of lines 6-24)	711,256	25.00
26.00	Total (line 5 plus line 25)	320,638	26.00
27.00	LOSS FROM DISPOSAL	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	320,638	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

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

Period:
From 08/01/2017
To 07/31/2018

Worksheet M-1
Date/Time Prepared:
12/21/2018 2:20 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	596,849	0	596,849	0	596,849	1.00
2.00	Physician Assistant	84,112	0	84,112	0	84,112	2.00
3.00	Nurse Practitioner	58,390	0	58,390	0	58,390	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	598,604	235,080	833,684	-142,450	691,234	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,337,955	235,080	1,573,035	-142,450	1,430,585	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)	1,337,955	235,080	1,573,035	-142,450	1,430,585	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,337,955	235,080	1,573,035	-142,450	1,430,585	32.00

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	596,849		1.00
2.00	Physician Assistant	0	84,112		2.00
3.00	Nurse Practitioner	0	58,390		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	691,234		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,430,585		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,430,585		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,430,585		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

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

Period:
From 08/01/2017
To 07/31/2018

Worksheet M-1
Date/Time Prepared:
12/21/2018 2:20 pm

		RHC II		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	49,750	0	49,750	0	49,750	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	111,764	0	111,764	0	111,764	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	81,422	50,597	132,019	-44,229	87,790	9.00
10.00	Subtotal (sum of lines 1 through 9)	242,936	50,597	293,533	-44,229	249,304	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)	242,936	50,597	293,533	-44,229	249,304	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	242,936	50,597	293,533	-44,229	249,304	32.00

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	49,750		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	111,764		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	87,790		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	249,304		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	249,304		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	249,304		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347

Period:
From 08/01/2017
To 07/31/2018

Worksheet M-2

Component CCN: 14-8530

Date/Time Prepared:
12/21/2018 2:20 pm

		RHC I				Cost
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.33	8,232	4,200	9,786	1.00
2.00	Physician Assistant	0.56	851	2,100	1,176	2.00
3.00	Nurse Practitioner	0.60	1,390	2,100	1,260	3.00
4.00	Subtotal (sum of lines 1 through 3)	3.49	10,473		12,222	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.49	10,473			8.00
9.00	Physician Services Under Agreements		0			9.00
						1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from wkst. M-1, col. 7, line 22)				1,430,585	10.00
11.00	Total nonreimbursable costs (from wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,430,585	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from worksheet. M-1, col. 7, line 31)				0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,180,815	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,180,815	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,180,815	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,180,815	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,611,400	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

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

Period:
From 08/01/2017
To 07/31/2018

Worksheet M-2
Date/Time Prepared:
12/21/2018 2:20 pm

		RHC II			Cost		
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.17	382	4,200	714		1.00
2.00	Physician Assistant	0.00	8	2,100	0		2.00
3.00	Nurse Practitioner	0.80	1,665	2,100	1,680		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.97	2,055		2,394	2,394	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.97	2,055			2,394	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from wkst. M-1, col. 7, line 22)					249,304	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)					249,304	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from worksheet. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					148,925	15.00
16.00	Total overhead (sum of lines 14 and 15)					148,925	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					148,925	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					148,925	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					398,229	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1347	Period: From 08/01/2017 To 07/31/2018	Worksheet M-3
	Component CCN: 14-8530		Date/Time Prepared: 12/21/2018 2:20 pm

		Title XVIII	RHC I	Cost
				1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from wkst. M-2, line 20)			2,611,400 1.00
2.00	Cost of vaccines and their administration (from wkst. M-4, line 15)			14,300 2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,597,100 3.00
4.00	Total visits (from wkst. M-2, column 5, line 8)			12,222 4.00
5.00	Physicians visits under agreement (from wkst. M-2, column 5, line 9)			0 5.00
6.00	Total adjusted visits (line 4 plus line 5)			12,222 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			212.49 7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	212.49	212.49	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,154	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	457,703	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	457,703	16.00
16.01	Total program charges (see instructions)(from contractor's records)		245,205	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,382	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,113	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.)		329,334	16.04
16.05	Total program cost (see instructions)	0	352,447	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,922	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		41,980	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		352,447	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		14,300	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		366,747	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		366,747	26.00
26.01	Sequestration adjustment (see instructions)		7,335	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		336,786	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		22,626	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1347	Period: From 08/01/2017	Worksheet M-3
	Component CCN: 14-8532	To 07/31/2018	Date/Time Prepared: 12/21/2018 2:20 pm

		Title XVIII	RHC II	Cost
				1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			398,229 1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			513 2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			397,716 3.00
4.00	Total visits (from Wkst. M-2, column 5, line 8)			2,394 4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0 5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,394 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			166.13 7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	166.13	166.13	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	410	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	68,113	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	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	68,113	16.00
16.01	Total program charges (see instructions)(from contractor's records)		46,983	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		373	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		541	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.)		48,878	16.04
16.05	Total program cost (see instructions)	0	49,419	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,474	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,027	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		49,419	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		513	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		49,932	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		49,932	26.00
26.01	Sequestration adjustment (see instructions)		999	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		52,692	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-3,759	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2017 To 07/31/2018	Worksheet M-4 Date/Time Prepared: 12/21/2018 2:20 pm
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		Title XVIII		RHC I		Cost	
		Pneumococcal	Influenza				
		1.00	2.00				
1.00	Health care staff cost (from wkst. M-1, col. 7, line 10)	1,430,585	1,430,585				1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000103	0.000209				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	147	299				3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,537	1,851				4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,684	2,150				5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from worksheet M-1, col. 7, line 22)	1,430,585	1,430,585				6.00
7.00	Total overhead (from wkst. M-2, line 19)	1,180,815	1,180,815				7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003973	0.001503				8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,691	1,775				9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	10,375	3,925				10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	36	105				11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	288.19	37.38				12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	36	105				13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	10,375	3,925				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)		14,300				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)		14,300				16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

Period:
From 08/01/2017
To 07/31/2018

Worksheet M-4
Date/Time Prepared:
12/21/2018 2:20 pm

		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from wkst. M-1, col. 7, line 10)		249,304	249,304	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000230	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	57	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	264	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	321	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from worksheet M-1, col. 7, line 22)		249,304	249,304	6.00
7.00	Total overhead (from wkst. M-2, line 19)		148,925	148,925	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.001288	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	192	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	513	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	15	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	34.20	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	15	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	513	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)			513	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)			513	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2017 To 07/31/2018	Worksheet M-5 Date/Time Prepared: 12/21/2018 2:20 pm
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		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
1.00	Total interim payments paid to hospital-based RHC/FQHC	1.00	351,662	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		03/08/2018	14,876	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)		-14,876	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		336,786	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		22,626	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		359,412	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1347 Component CCN: 14-8532	Period: From 08/01/2017 To 07/31/2018	Worksheet M-5 Date/Time Prepared: 12/21/2018 2:20 pm
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		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		52,692	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		52,692	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,759	6.02
7.00	Total Medicare program liability (see instructions)		48,933	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00