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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141347	Period: From 08/01/2013 To 07/31/2014	Worksheet S Parts I-III Date/Time Prepared: 12/22/2014 9:54 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 12/22/2014 Time: 9:54 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CARLINVILLE AREA HOSPITAL (141347) for the cost reporting period beginning 08/01/2013 and ending 07/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	254,019	327,140	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	84,433	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RHC - CARLINVILLE I	0		7,495		0	10.00
10.01	RHC - GIRARD II	0		13,298		0	10.01
200.00	Total	0	338,452	347,933	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 12/19/2014 5:05 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 20733 NORTH BROAD STREET	PO Box:			1.00
2.00	City: CARLINVILLE	State: IL	Zip Code: 62626-	County: MACOUPIN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CARLINVILLE AREA HOSPITAL	141347	99914	1	07/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CARLINVILLE AREA HOSPITAL SWING BED	14Z347	99914		07/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HOSPITAL-BASED HHA	147249	99914		01/05/1984	N	P	N	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	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	GIRARD RHC	148532	99914		02/12/2014	N	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	08/01/2013	07/31/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 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 col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 12/19/2014 5:05 pm

		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 in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			39.00

		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 Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 12/19/2014 5:05 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 12/19/2014 5:05 pm

		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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		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
	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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 12/19/2014 5:05 pm

		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: 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 would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	Y	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If 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 hospital providers) based on the definition in CMS 15-1, §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:	151,816	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141347	Period: From 08/01/2013 To 07/31/2014	Worksheet S-2 Part I Date/Time Prepared: 12/19/2014 5:05 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
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, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						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 Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
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)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 12/19/2014 5:05 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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	11/24/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 12/19/2014 5:05 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				Y	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 12/19/2014 5:05 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	11/24/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CFO		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 12/19/2014 5:05 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	21,288.00	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	21,288.00	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	21,288.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	88.00				0	26.00
26.01	RHC - GIRARD	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 12/19/2014 5:05 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	729	56	887			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	1,600	0	1,600			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	108			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,329	56	2,595			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)	2,329	56	2,595	0.00	125.10	14.00
15.00	CAH visits	11,600	2,454	21,572			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	0	0	0	0.00	0.00	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	770	255	2,713	0.00	5.73	26.00
26.01	RHC - GIRARD	171	208	765	0.00	3.32	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	134.15	27.00
28.00	Observation Bed Days		14	144			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 12/19/2014 5:05 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	231	22	287	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						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	231	22	287	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	0.00					26.00
26.01	RHC - GIRARD	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141347 Component CCN: 148530 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-8 Date/Time Prepared: 12/19/2014 5:05 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1115 EAST MORGAN STREET, #2	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	CARLINVILLE	IL	62626	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

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

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

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

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

			County				
			4.00				
2.00	City, State, Zip Code, County		MACOUPIN				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:00	07:30	16:00	07:30	16:00	11.00

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

Provider CCN: 141347
Component CCN: 148530

Period:
From 08/01/2013
To 07/31/2014

Worksheet S-8

Date/Time Prepared:
12/19/2014 5:05 pm

Rural Health Clinic (RHC) I

Cost

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

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

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-8 Date/Time Prepared: 12/19/2014 5:05 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	205 SOUTH THRID STREET	1.00
		City / State / Zip Code	
		1.00 / 2.00 / 3.00	
2.00	City, State, Zip Code, County	GIRARD IL 62640	2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award / Date	
		1.00 / 2.00	
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
		1.00 / 2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

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

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

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

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

Provider CCN: 141347
Component CCN: 148532

Period:
From 08/01/2013
To 07/31/2014

Worksheet S-8

Date/Time Prepared:
12/19/2014 5:05 pm

Rural Health Clinic (RHC) II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet S-10 | Date/Time Prepared: 12/19/2014 5:05 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.546650	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,534,761	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,306,412	5.00
6.00	Medicaid charges	5,610,364	6.00
7.00	Medicaid cost (line 1 times line 6)	3,066,905	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)	225,732	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	42,283	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	225,732	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	553,260	0	553,260	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	302,440	0	302,440	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	302,440	0	302,440	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,116,050	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	372,747	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	743,303	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	406,327	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	708,767	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	934,499	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A | Date/Time Prepared: 12/19/2014 5:05 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		1,278,555	1,278,555	1,535,156	2,813,711	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		806,855	806,855	13,130	819,985	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,625,954	1,625,954	-1,297,294	328,660	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,192,846	2,106,100	3,298,946	224,396	3,523,342	5.00
7.00	00700	OPERATION OF PLANT	208,396	344,143	552,539	33,697	586,236	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,182	57,182	0	57,182	8.00
9.00	00900	HOUSEKEEPING	187,349	30,000	217,349	43,900	261,249	9.00
10.00	01000	DIETARY	136,721	175,753	312,474	31,491	343,965	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	365,245	8,886	374,131	54,712	428,843	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,696	82,327	249,023	54,513	303,536	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	191,269	2,113	193,382	16,280	209,662	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	860,588	85,309	945,897	168,126	1,114,023	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	157,842	274,968	432,810	22,667	455,477	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	437,916	591,965	1,029,881	88,233	1,118,114	54.00
60.00	06000	LABORATORY	530,008	508,306	1,038,314	105,564	1,143,878	60.00
65.00	06500	RESPIRATORY THERAPY	203,690	44,182	247,872	33,514	281,386	65.00
66.00	06600	PHYSICAL THERAPY	483,784	34,808	518,592	72,104	590,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,599	2,864	146,463	22,764	169,227	67.00
69.00	06900	ELECTROCARDIOLOGY	59,785	14,226	74,011	16,186	90,197	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,910	157,316	229,226	17,435	246,661	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,209	21,209	18,200	39,409	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	187,174	703,373	890,547	32,054	922,601	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	413,752	140,741	554,493	-146,615	407,878	88.00
88.01	08801	RHC - GIRARD	178,100	110,466	288,566	-154,355	134,211	88.01
90.00	09000	CLINIC	157,591	174,541	332,132	25,344	357,476	90.00
91.00	09100	EMERGENCY	613,336	1,496,914	2,110,250	112,533	2,222,783	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,499,345	1,499,345	-1,499,345	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,947,597	12,378,401	19,325,998	-355,610	18,970,388	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	343,921	343,921	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	1,949	1,949	194.00
194.01	07951	FUND DEVELOPMENT	13,146	2,308	15,454	9,740	25,194	194.01
200.00		TOTAL (SUM OF LINES 118-199)	6,960,743	12,380,709	19,341,452	0	19,341,452	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A | Date/Time Prepared: 12/19/2014 5:05 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-35,891	2,777,820		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-263,395	556,590		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	328,660		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-132,547	3,390,795		5.00
7.00	00700	OPERATION OF PLANT	0	586,236		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57,182		8.00
9.00	00900	HOUSEKEEPING	0	261,249		9.00
10.00	01000	DIETARY	-56,701	287,264		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	428,843		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-235	303,301		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	209,662		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,114,023		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,421	453,056		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,917	1,106,197		54.00
60.00	06000	LABORATORY	-150	1,143,728		60.00
65.00	06500	RESPIRATORY THERAPY	-26,384	255,002		65.00
66.00	06600	PHYSICAL THERAPY	-463	590,233		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	169,227		67.00
69.00	06900	ELECTROCARDIOLOGY	-12,232	77,965		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	246,661		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,409		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-36,189	886,412		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	407,878		88.00
88.01	08801	RHC - GIRARD	0	134,211		88.01
90.00	09000	CLINIC	-20,874	336,602		90.00
91.00	09100	EMERGENCY	-1,128,055	1,094,728		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
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,727,454	17,242,934		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	343,921		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	1,949		194.00
194.01	07951	FUND DEVELOPMENT	0	25,194		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,727,454	17,613,998		200.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-6 | Date/Time Prepared: 12/19/2014 5:05 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - RECLASS NONREIMBURSEABLE COSTS					
1.00	NONREIMBURSABLE COSTS CENTERS	194.00	0	1,949		1.00
	TOTALS		0	1,949		
	C - INSURANCE EXPENSE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	58,251		1.00
	TOTALS		0	58,251		
	E - INTEREST EXPENSE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,361		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,491,984		2.00
	TOTALS		0	1,499,345		
	H - DIRECTLY ASSIGN FICA					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,924		1.00
2.00	OPERATION OF PLANT	7.00	0	15,603		2.00
3.00	HOUSEKEEPING	9.00	0	13,745		3.00
4.00	DIETARY	10.00	0	1,336		4.00
5.00	NURSING ADMINISTRATION	13.00	0	30,588		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	12,296		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	65,598		7.00
8.00	OPERATING ROOM	50.00	0	10,712		8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	10,249		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,624		10.00
11.00	LABORATORY	60.00	0	39,223		11.00
12.00	RESPIRATORY THERAPY	65.00	0	15,421		12.00
13.00	PHYSICAL THERAPY	66.00	0	35,918		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	10,702		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	4,124		15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,373		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,961		17.00
18.00	RHC - CARLINVILLE	88.00	0	16,913		18.00
19.00	RHC - GIRARD	88.01	0	6,989		19.00
20.00	CLINIC	90.00	0	13,282		20.00
21.00	EMERGENCY	91.00	0	46,191		21.00
22.00	FUND DEVELOPMENT	194.01	0	3,709		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	16,716		23.00
	TOTALS		0	501,197		
	I - DIRECTLY ASSIGN HEALTH INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	150,776		1.00
2.00	OPERATION OF PLANT	7.00	0	18,094		2.00
3.00	HOUSEKEEPING	9.00	0	30,155		3.00
4.00	DIETARY	10.00	0	30,155		4.00
5.00	NURSING ADMINISTRATION	13.00	0	24,124		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	42,217		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	102,528		7.00
8.00	OPERATING ROOM	50.00	0	30,155		8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	6,031		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,248		10.00
11.00	LABORATORY	60.00	0	66,341		11.00
12.00	RESPIRATORY THERAPY	65.00	0	18,093		12.00
13.00	PHYSICAL THERAPY	66.00	0	36,186		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	12,062		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	12,062		15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,062		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	18,093		17.00
18.00	RHC - CARLINVILLE	88.00	0	24,124		18.00
19.00	RHC - GIRARD	88.01	0	8,293		19.00
20.00	CLINIC	90.00	0	12,062		20.00
21.00	EMERGENCY	91.00	0	66,342		21.00
22.00	FUND DEVELOPMENT	194.01	0	6,031		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	21,863		23.00
	TOTALS		0	796,097		
	J - RECLASS RHC COSTS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	114,411	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43,505		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	82,563	0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	64,863		4.00
	TOTALS		196,974	108,368		
	K - RECLASS IMPLANT EXPENSE					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	18,200		1.00
	TOTALS		0	18,200		

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-6 | Date/Time Prepared: 12/19/2014 5:05 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - RECLASS RHC ADMIN SALARIES TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	51,947	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		51,947	0		
500.00	Grand Total: Increases		248,921	2,983,407		500.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-6 | Date/Time Prepared: 12/19/2014 5:05 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - RECLASS NONREIMBURSEABLE COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,949	9		1.00
	TOTALS		0	1,949			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58,251	0		1.00
	TOTALS		0	58,251			
	E - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,499,345	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,499,345			
	H - DIRECTLY ASSIGN FICA						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	501,197	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
	TOTALS		0	501,197			
	I - DIRECTLY ASSIGN HEALTH INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	796,097	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
	TOTALS		0	796,097			
	J - RECLASS RHC COSTS						
1.00	RHC - CARLINVILLE	88.00	114,411	0	0		1.00
2.00	RHC - CARLINVILLE	88.00	0	43,505	0		2.00
3.00	RHC - GIRARD	88.01	82,563	0	0		3.00
4.00	RHC - GIRARD	88.01	0	64,863	0		4.00
	TOTALS		196,974	108,368			
	K - RECLASS IMPLANT EXPENSE						
1.00	OPERATING ROOM	50.00	0	18,200	0		1.00
	TOTALS		0	18,200			
	L - RECLASS RHC ADMIN SALARIES TO ADMIN						
1.00	RHC - CARLINVILLE	88.00	29,736	0	0		1.00
2.00	RHC - GIRARD	88.01	22,211	0	0		2.00
	TOTALS		51,947	0			

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-6 | Date/Time Prepared: 12/19/2014 5:05 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
500.00	Grand Total: Decreases		248,921	2,983,407			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 12/19/2014 5:05 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	561,322	0	0	0	44,150	1.00
2.00	Land Improvements	1,358,814	0	0	0	44,180	2.00
3.00	Buildings and Fixtures	19,884,618	34,729	0	34,729	72,035	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,060,602	134,703	0	134,703	75,283	6.00
7.00	HIT designated Assets	1,032,307	155,999	0	155,999	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,897,663	325,431	0	325,431	235,648	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,897,663	325,431	0	325,431	235,648	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	517,172	0	1.00
2.00	Land Improvements	1,314,634	0	2.00
3.00	Buildings and Fixtures	19,847,312	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	5,120,022	0	6.00
7.00	HIT designated Assets	1,188,306	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,987,446	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	27,987,446	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 12/19/2014 5:05 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	1,278,555	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	806,855	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,085,410	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	1,278,555		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	806,855		2.00
3.00	Total (sum of lines 1-2)	0	2,085,410		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 12/19/2014 5:05 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	21,679,118	0	21,679,118	0.774602	45,121	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,308,328	0	6,308,328	0.225398	13,130	2.00
3.00	Total (sum of lines 1-2)	27,987,446	0	27,987,446	1.000000	58,251	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	45,121	2,732,699	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	13,130	543,460	0	2.00
3.00	Total (sum of lines 1-2)	0	0	58,251	3,276,159	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	45,121	0	0	2,777,820	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	13,130	0	0	556,590	2.00
3.00	Total (sum of lines 1-2)	0	58,251	0	0	3,334,410	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-8 | Date/Time Prepared: 12/19/2014 5:05 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-29,755	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	-1,093	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	-1,985	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	-1,128,055			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	-53,837	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	-36,189	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-235	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-263,395	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-8 | Date/Time Prepared: 12/19/2014 5:05 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	DIETARY DISCOUNTS	B	-2,864	DIETARY	10.00	0	33.00
33.01	RADIOLOGY DISCOUNTS	B	-11,917	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	PT PROF FEES	B	-463	PHYSICAL THERAPY	66.00	0	33.02
33.03			0		0.00	0	33.03
33.04	CONTRACT LAB	B	-150	LABORATORY	60.00	0	33.04
33.05	SUPPLIES	B	-2,421	OPERATING ROOM	50.00	0	33.05
33.06	AHA & IHA DUES	A	-8,162	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07			0		0.00	0	33.07
36.00	TELEVISION DEPRECIATION	A	-4,273	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00			0		0.00	0	37.00
39.00	MED STAFF RELATIONS	A	-7,768	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00	ADVERTISING	A	-99,384	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	TELEPHONE DEPRECIATION	A	-1,863	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-4,918	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-20,874	CLINIC	90.00	0	44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,553	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	INSURANCE PROCEEDS	A	-4,431	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05			0		0.00	0	44.05
44.06			0		0.00	0	44.06
44.07	PROP TAXES-POGUE BLDG	A	-647	ADMINISTRATIVE & GENERAL	5.00	0	44.07
45.00	PHYSICIAN RECRUITMENT	A	-1,606	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03			0		0.00	0	45.03
45.04			0		0.00	0	45.04
45.05	EKG PROFESSIONAL FEES	A	-12,232	ELECTROCARDIOLOGY	69.00	0	45.05
45.06	SLEEP STUDY PROFESSONAL FEES	A	-26,384	RESPIRATORY THERAPY	65.00	0	45.06
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.09			0		0.00	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,727,454				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 12/19/2014 5:05 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	1,441,973	1,128,055	313,918	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,441,973	1,128,055	313,918		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	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	1,128,055		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,128,055		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/19/2014 5:05 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	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					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	0.00	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)	0.00	0.00	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)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					0	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)					0	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)					0	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/19/2014 5:05 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	0.00	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	0	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)	0	63.00
64.00	Total cost of outside supplier services (from your records)	0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/19/2014 5:05 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					0.57	7.00
8.00	Optional travel expense rate per mile					0.57	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	277.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.00	35.00	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)					19,390	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					19,390	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)					19,390	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					70.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					54,600	22.00
23.00	Total salary equivalency (see instructions)					54,600	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/19/2014 5:05 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.00	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	54,600		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	54,600		63.00
64.00	Total cost of outside supplier services (from your records)	13,850		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B Part I | Date/Time Prepared: 12/19/2014 5:05 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,777,820	2,777,820				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	556,590		556,590			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	328,660	0	0	328,660		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,390,795	561,403	87,561	58,775	4,098,534	5.00
7.00	00700	OPERATION OF PLANT	586,236	388,043	23,591	9,840	1,007,710	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,182	0	0	0	57,182	8.00
9.00	00900	HOUSEKEEPING	261,249	18,154	19	8,846	288,268	9.00
10.00	01000	DIETARY	287,264	69,890	17,591	6,455	381,200	10.00
11.00	01100	CAFETERIA	0	70,425	0	0	70,425	11.00
13.00	01300	NURSING ADMINISTRATION	428,843	11,535	657	17,245	458,280	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	303,301	52,028	2,893	7,871	366,093	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	209,662	3,845	36	9,031	222,574	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,114,023	545,489	36,891	40,634	1,737,037	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	453,056	256,002	58,932	7,453	775,443	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,106,197	171,901	249,710	20,677	1,548,485	54.00
60.00	06000	LABORATORY	1,143,728	71,690	11,631	25,025	1,252,074	60.00
65.00	06500	RESPIRATORY THERAPY	255,002	94,906	18,879	9,617	378,404	65.00
66.00	06600	PHYSICAL THERAPY	590,233	138,854	8,725	22,842	760,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,227	8,469	0	6,780	184,476	67.00
69.00	06900	ELECTROCARDIOLOGY	77,965	0	3,902	2,823	84,690	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	246,661	40,250	1,043	3,395	291,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,409	0	0	0	39,409	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	886,412	31,343	4,024	8,838	930,617	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	407,878	0	0	12,730	420,608	88.00
88.01	08801	RHC - GIRARD	134,211	0	0	3,462	137,673	88.01
90.00	09000	CLINIC	336,602	124,254	2,939	7,441	471,236	90.00
91.00	09100	EMERGENCY	1,094,728	107,463	27,181	28,959	1,258,331	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,242,934	2,765,944	556,205	318,739	17,220,752	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,907	20	0	8,927	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	343,921	0	55	9,300	353,276	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	1,949	0	0	0	1,949	194.00
194.01	07951	FUND DEVELOPMENT	25,194	2,969	310	621	29,094	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,613,998	2,777,820	556,590	328,660	17,613,998	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B Part I | Date/Time Prepared: 12/19/2014 5:05 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,098,534					5.00
7.00	00700	OPERATION OF PLANT	305,586	1,313,296				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,340	0	74,522			8.00
9.00	00900	HOUSEKEEPING	87,417	13,040	0	388,725		9.00
10.00	01000	DIETARY	115,598	50,201	0	13,477	560,476	10.00
11.00	01100	CAFETERIA	21,356	50,585	0	13,581	317,808	11.00
13.00	01300	NURSING ADMINISTRATION	138,972	8,285	0	2,224	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	111,017	37,371	0	10,033	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	67,495	2,762	0	741	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	526,750	391,819	37,376	105,191	242,668	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	235,152	183,883	5,255	49,367	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	469,575	123,474	7,406	33,149	0	54.00
60.00	06000	LABORATORY	379,689	51,494	2	13,825	0	60.00
65.00	06500	RESPIRATORY THERAPY	114,750	68,170	0	18,302	0	65.00
66.00	06600	PHYSICAL THERAPY	230,667	99,737	3,875	26,777	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	55,942	6,083	0	1,633	0	67.00
69.00	06900	ELECTROCARDIOLOGY	25,682	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,351	28,911	0	7,762	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,951	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	282,208	22,513	0	6,044	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	127,549	0	0	10,859	0	88.00
88.01	08801	RHC - GIRARD	41,749	0	0	11,760	0	88.01
90.00	09000	CLINIC	142,901	89,250	19	23,961	0	90.00
91.00	09100	EMERGENCY	381,586	77,189	20,589	20,723	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,979,283	1,304,767	74,522	369,409	560,476	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,707	6,397	0	1,718	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107,130	0	0	17,025	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	591	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	8,823	2,132	0	573	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,098,534	1,313,296	74,522	388,725	560,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B Part I | Date/Time Prepared: 12/19/2014 5:05 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	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	473,755					11.00
13.00	01300	NURSING ADMINISTRATION	24,439	632,200				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,885	0	549,399			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	5,233	14,054	6,579	319,438		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	118,801	319,086	30,196	0	3,508,924	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,699	42,169	18,860	0	1,325,828	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	319,438	319,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,314	0	153,807	0	2,380,210	54.00
60.00	06000	LABORATORY	57,062	0	117,044	0	1,871,190	60.00
65.00	06500	RESPIRATORY THERAPY	22,157	0	16,544	0	618,327	65.00
66.00	06600	PHYSICAL THERAPY	38,023	0	38,810	0	1,198,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,245	0	12,969	0	272,348	67.00
69.00	06900	ELECTROCARDIOLOGY	5,678	0	12,601	0	128,651	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,074	0	16,361	0	441,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,069	0	52,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,530	39,028	32,633	0	1,327,573	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	5,812	0	564,828	88.00
88.01	08801	RHC - GIRARD	0	0	1,308	0	192,490	88.01
90.00	09000	CLINIC	17,592	47,252	11,721	0	803,932	90.00
91.00	09100	EMERGENCY	63,520	170,611	73,085	0	2,065,634	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	472,252	632,200	549,399	319,438	17,072,153	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	19,749	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	477,431	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	2,540	194.00
194.01	07951	FUND DEVELOPMENT	1,503	0	0	0	42,125	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	473,755	632,200	549,399	319,438	17,613,998	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B Part I | Date/Time Prepared: 12/19/2014 5:05 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	3,508,924		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,325,828		50.00
53.00	05300	ANESTHESIOLOGY	0	319,438		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,380,210		54.00
60.00	06000	LABORATORY	0	1,871,190		60.00
65.00	06500	RESPIRATORY THERAPY	0	618,327		65.00
66.00	06600	PHYSICAL THERAPY	0	1,198,543		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	272,348		67.00
69.00	06900	ELECTROCARDIOLOGY	0	128,651		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	441,808		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,429		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,327,573		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	564,828		88.00
88.01	08801	RHC - GIRARD	0	192,490		88.01
90.00	09000	CLINIC	0	803,932		90.00
91.00	09100	EMERGENCY	0	2,065,634		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	17,072,153		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	19,749		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	477,431		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	2,540		194.00
194.01	07951	FUND DEVELOPMENT	0	42,125		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	17,613,998		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B Part II | Date/Time Prepared: 12/19/2014 5:05 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,657	561,403	87,561	689,621	0	5.00
7.00	00700	OPERATION OF PLANT	9,500	388,043	23,591	421,134	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	18,154	19	18,173	0	9.00
10.00	01000	DIETARY	1,565	69,890	17,591	89,046	0	10.00
11.00	01100	CAFETERIA	0	70,425	0	70,425	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,535	657	12,192	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,028	2,893	54,921	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	3,845	36	3,881	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,905	545,489	36,891	608,285	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,631	256,002	58,932	503,565	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,056	171,901	249,710	440,667	0	54.00
60.00	06000	LABORATORY	68,399	71,690	11,631	151,720	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,474	94,906	18,879	115,259	0	65.00
66.00	06600	PHYSICAL THERAPY	0	138,854	8,725	147,579	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,469	0	8,469	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,902	3,902	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40,250	1,043	41,293	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	84,678	31,343	4,024	120,045	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	14,761	0	0	14,761	0	88.00
88.01	08801	RHC - GIRARD	11,294	0	0	11,294	0	88.01
90.00	09000	CLINIC	0	124,254	2,939	127,193	0	90.00
91.00	09100	EMERGENCY	0	107,463	27,181	134,644	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	465,920	2,765,944	556,205	3,788,069	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,907	20	8,927	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,728	0	55	20,783	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	2,969	310	3,279	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	486,648	2,777,820	556,590	3,821,058	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B Part II | Date/Time Prepared: 12/19/2014 5:05 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	689,621					5.00
7.00	00700	OPERATION OF PLANT	51,418	472,552				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,918	0	2,918			8.00
9.00	00900	HOUSEKEEPING	14,709	4,692	0	37,574		9.00
10.00	01000	DIETARY	19,451	18,063	0	1,303	127,863	10.00
11.00	01100	CAFETERIA	3,593	18,202	0	1,313	72,502	11.00
13.00	01300	NURSING ADMINISTRATION	23,384	2,981	0	215	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,680	13,447	0	970	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	11,357	994	0	72	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	88,626	140,983	1,463	10,167	55,361	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,567	66,165	206	4,772	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,011	44,429	290	3,204	0	54.00
60.00	06000	LABORATORY	63,887	18,529	0	1,336	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,308	24,529	0	1,769	0	65.00
66.00	06600	PHYSICAL THERAPY	38,812	35,888	152	2,588	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,413	2,189	0	158	0	67.00
69.00	06900	ELECTROCARDIOLOGY	4,321	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,866	10,403	0	750	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,011	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,485	8,101	0	584	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	21,462	0	0	1,050	0	88.00
88.01	08801	RHC - GIRARD	7,025	0	0	1,137	0	88.01
90.00	09000	CLINIC	24,045	32,114	1	2,316	0	90.00
91.00	09100	EMERGENCY	64,206	27,774	806	2,003	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	669,555	469,483	2,918	35,707	127,863	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	456	2,302	0	166	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,026	0	0	1,646	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	99	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	1,485	767	0	55	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	689,621	472,552	2,918	37,574	127,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B Part II | Date/Time Prepared: 12/19/2014 5:05 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	166,035					11.00
13.00	01300	NURSING ADMINISTRATION	8,565	47,337				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,721	0	96,739			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,834	1,052	1,159	20,349		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,637	23,893	5,318		975,733	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,502	3,157	3,321		626,255	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,530	0	27,075		610,206	54.00
60.00	06000	LABORATORY	19,998	0	20,612		276,082	60.00
65.00	06500	RESPIRATORY THERAPY	7,765	0	2,913		171,543	65.00
66.00	06600	PHYSICAL THERAPY	13,326	0	6,835		245,180	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,941	0	2,284		26,454	67.00
69.00	06900	ELECTROCARDIOLOGY	1,990	0	2,219		12,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,180	0	2,881		73,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	188		2,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,092	2,922	5,747		189,976	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	1,023		38,296	88.00
88.01	08801	RHC - GIRARD	0	0	230		19,686	88.01
90.00	09000	CLINIC	6,165	3,538	2,064		197,436	90.00
91.00	09100	EMERGENCY	22,262	12,775	12,870		277,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	165,508	47,337	96,739	0	3,742,191	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		11,851	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		40,455	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		99	194.00
194.01	07951	FUND DEVELOPMENT	527	0	0		6,113	194.01
200.00		Cross Foot Adjustments				20,349	20,349	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	166,035	47,337	96,739	20,349	3,821,058	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B Part II | Date/Time Prepared: 12/19/2014 5:05 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	975,733		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	626,255		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	610,206		54.00
60.00	06000	LABORATORY	0	276,082		60.00
65.00	06500	RESPIRATORY THERAPY	0	171,543		65.00
66.00	06600	PHYSICAL THERAPY	0	245,180		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,454		67.00
69.00	06900	ELECTROCARDIOLOGY	0	12,432		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	73,373		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,199		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	189,976		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	38,296		88.00
88.01	08801	RHC - GIRARD	0	19,686		88.01
90.00	09000	CLINIC	0	197,436		90.00
91.00	09100	EMERGENCY	0	277,340		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,742,191		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,851		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	40,455		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	99		194.00
194.01	07951	FUND DEVELOPMENT	0	6,113		194.01
200.00		Cross Foot Adjustments	0	20,349		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	3,821,058		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B-1 | Date/Time Prepared: 12/19/2014 5:05 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	57,075					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		505,261				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,960,743			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,535	79,486	1,244,793	-4,098,534	13,515,464	5.00
7.00	00700	OPERATION OF PLANT	7,973	21,415	208,396	0	1,007,710	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	57,182	8.00
9.00	00900	HOUSEKEEPING	373	17	187,349	0	288,268	9.00
10.00	01000	DIETARY	1,436	15,969	136,721	0	381,200	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	70,425	11.00
13.00	01300	NURSING ADMINISTRATION	237	596	365,245	0	458,280	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	2,626	166,696	0	366,093	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	33	191,269	0	222,574	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	33,489	860,588	0	1,737,037	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	53,497	157,842	0	775,443	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	226,684	437,916	0	1,548,485	54.00
60.00	06000	LABORATORY	1,473	10,558	530,008	0	1,252,074	60.00
65.00	06500	RESPIRATORY THERAPY	1,950	17,138	203,690	0	378,404	65.00
66.00	06600	PHYSICAL THERAPY	2,853	7,920	483,784	0	760,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	0	143,599	0	184,476	67.00
69.00	06900	ELECTROCARDIOLOGY	0	3,542	59,785	0	84,690	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	947	71,910	0	291,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	39,409	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	3,653	187,174	0	930,617	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	269,605	0	420,608	88.00
88.01	08801	RHC - GIRARD	0	0	73,326	0	137,673	88.01
90.00	09000	CLINIC	2,553	2,668	157,591	0	471,236	90.00
91.00	09100	EMERGENCY	2,208	24,674	613,336	0	1,258,331	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,831	504,912	6,750,623	-4,098,534	13,122,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	8,927	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50	196,974	0	353,276	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	1,949	194.00
194.01	07951	FUND DEVELOPMENT	61	281	13,146	0	29,094	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)	2,777,820	556,590	328,660		4,098,534	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.669645	1.101589	0.047216		0.303248	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		689,621	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.051025	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B-1 | Date/Time Prepared: 12/19/2014 5:05 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	37,567					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	96,920				8.00
9.00	00900	HOUSEKEEPING	373	0	41,418			9.00
10.00	01000	DIETARY	1,436	0	1,436	24,697		10.00
11.00	01100	CAFETERIA	1,447	0	1,447	14,004	8,510	11.00
13.00	01300	NURSING ADMINISTRATION	237	0	237	0	439	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	0	1,069	0	447	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	94	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	48,609	11,208	10,693	2,134	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	6,835	5,260	0	282	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	9,632	3,532	0	796	54.00
60.00	06000	LABORATORY	1,473	2	1,473	0	1,025	60.00
65.00	06500	RESPIRATORY THERAPY	1,950	0	1,950	0	398	65.00
66.00	06600	PHYSICAL THERAPY	2,853	5,040	2,853	0	683	66.00
67.00	06700	OCCUPATIONAL THERAPY	174	0	174	0	202	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	0	827	0	163	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	261	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	1,157	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	1,253	0	0	88.01
90.00	09000	CLINIC	2,553	25	2,553	0	316	90.00
91.00	09100	EMERGENCY	2,208	26,777	2,208	0	1,141	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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,323	96,920	39,360	24,697	8,483	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	0	183	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,814	0	0	192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	0	61	0	27	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)	1,313,296	74,522	388,725	560,476	473,755	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.958767	0.768902	9.385412	22.694092	55.670388	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	472,552	2,918	37,574	127,863	166,035	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.578912	0.030107	0.907190	5.177268	19.510576	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet B-1 | Date/Time Prepared: 12/19/2014 5:05 pm

		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	87,943				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,230,501			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,955	374,001	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	44,387	1,716,473			30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,866	1,072,074	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,743,490	0		54.00
60.00	06000	LABORATORY	0	6,653,236	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	940,424	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,206,128	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	737,192	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	716,284	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	930,043	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	60,760	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,429	1,855,003	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	330,360	0		88.00
88.01	08801	RHC - GIRARD	0	74,335	0		88.01
90.00	09000	CLINIC	6,573	666,247	0		90.00
91.00	09100	EMERGENCY	23,733	4,154,451	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,943	31,230,501	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	0	0	0		194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	632,200	549,399	319,438		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.188747	0.017592	3,194.380000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,337	96,739	20,349		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.538269	0.003098	203.490000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet C Part I Date/Time Prepared: 12/19/2014 5:05 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,508,924		3,508,924	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,325,828		1,325,828	0	0	50.00
53.00	05300	ANESTHESIOLOGY	319,438		319,438	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,380,210		2,380,210	0	0	54.00
60.00	06000	LABORATORY	1,871,190		1,871,190	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	618,327	0	618,327	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,198,543	0	1,198,543	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	272,348	0	272,348	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	128,651		128,651	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	441,808		441,808	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,429		52,429	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,327,573		1,327,573	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	564,828		564,828	0	0	88.00
88.01	08801	RHC - GIRARD	192,490		192,490	0	0	88.01
90.00	09000	CLINIC	803,932		803,932	0	0	90.00
91.00	09100	EMERGENCY	2,065,634		2,065,634	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	191,235		191,235		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		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)	17,263,388	0	17,263,388	0	0	200.00
201.00		Less Observation Beds	191,235		191,235		0	201.00
202.00		Total (see instructions)	17,072,153	0	17,072,153	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet C Part I Date/Time Prepared: 12/19/2014 5:05 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,405,008		1,405,008			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,150	1,068,924	1,072,074	1.236694	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	994	373,007	374,001	0.854110	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,460	8,302,030	8,743,490	0.272227	0.000000	54.00
60.00	06000	LABORATORY	595,513	6,057,723	6,653,236	0.281245	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	164,045	776,379	940,424	0.657498	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	533,803	1,672,325	2,206,128	0.543279	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	502,346	234,846	737,192	0.369440	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	33,620	682,664	716,284	0.179609	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	335,890	594,153	930,043	0.475040	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	60,760	60,760	0.862887	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	770,647	1,084,356	1,855,003	0.715672	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	330,360	330,360			88.00
88.01	08801	RHC - GIRARD	0	74,335	74,335			88.01
90.00	09000	CLINIC	1,782	664,465	666,247	1.206658	0.000000	90.00
91.00	09100	EMERGENCY	76,269	4,078,182	4,154,451	0.497210	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,459	302,006	311,465	0.613986	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	4,873,986	26,356,515	31,230,501			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,873,986	26,356,515	31,230,501			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet C Part I Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RHC - CARLINVILLE		88.00
88.01	08801	RHC - GIRARD		88.01
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D Part II Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	626,255	1,072,074	0.584153	3,150	1,840	50.00
53.00	05300	ANESTHESIOLOGY	0	374,001	0.000000	994	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	610,206	8,743,490	0.069790	291,757	20,362	54.00
60.00	06000	LABORATORY	276,082	6,653,236	0.041496	307,423	12,757	60.00
65.00	06500	RESPIRATORY THERAPY	171,543	940,424	0.182410	77,869	14,204	65.00
66.00	06600	PHYSICAL THERAPY	245,180	2,206,128	0.111136	69,798	7,757	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,454	737,192	0.035885	28,777	1,033	67.00
69.00	06900	ELECTROCARDIOLOGY	12,432	716,284	0.017356	21,004	365	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,373	930,043	0.078892	151,383	11,943	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,199	60,760	0.036192	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	189,976	1,855,003	0.102413	265,763	27,218	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	38,296	330,360	0.115922	0	0	88.00
88.01	08801	RHC - GIRARD	19,686	74,335	0.264828	0	0	88.01
90.00	09000	CLINIC	197,436	666,247	0.296341	0	0	90.00
91.00	09100	EMERGENCY	277,340	4,154,451	0.066757	10,059	672	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	136,281	311,465	0.437548	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,902,739	29,825,493		1,227,977	98,151	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D Part IV | Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	319,438	0	0	0	319,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	319,438	0	0	0	319,438	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D Part IV Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,072,074	0.000000	0.000000	3,150	50.00
53.00	05300	ANESTHESIOLOGY	0	374,001	0.854110	0.000000	994	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,743,490	0.000000	0.000000	291,757	54.00
60.00	06000	LABORATORY	0	6,653,236	0.000000	0.000000	307,423	60.00
65.00	06500	RESPIRATORY THERAPY	0	940,424	0.000000	0.000000	77,869	65.00
66.00	06600	PHYSICAL THERAPY	0	2,206,128	0.000000	0.000000	69,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	737,192	0.000000	0.000000	28,777	67.00
69.00	06900	ELECTROCARDIOLOGY	0	716,284	0.000000	0.000000	21,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	930,043	0.000000	0.000000	151,383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	60,760	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,855,003	0.000000	0.000000	265,763	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	330,360	0.000000	0.000000	0	88.00
88.01	08801	RHC - GIRARD	0	74,335	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	666,247	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,154,451	0.000000	0.000000	10,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	311,465	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	29,825,493			1,227,977	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D Part IV Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	849	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	0	0		88.00
88.01	08801	RHC - GIRARD	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	849	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D Part V Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.236694	0	675,152	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.854110	0	251,343	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.272227	0	3,524,289	0	0	54.00
60.00	06000	LABORATORY	0.281245	0	2,985,515	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.657498	0	415,440	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.543279	0	559,026	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.369440	0	46,758	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.179609	0	373,703	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.475040	0	333,235	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.862887	0	50,520	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.715672	0	703,494	456	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0.000000				0	88.00
88.01	08801	RHC - GIRARD	0.000000				0	88.01
90.00	09000	CLINIC	1.206658	0	488,875	0	0	90.00
91.00	09100	EMERGENCY	0.497210	0	1,447,413	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.613986	0	147,153	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	12,001,916	456	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	12,001,916	456	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D Part V Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	834,956	0		50.00
53.00	05300	ANESTHESIOLOGY	214,675	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,407	0		54.00
60.00	06000	LABORATORY	839,661	0		60.00
65.00	06500	RESPIRATORY THERAPY	273,151	0		65.00
66.00	06600	PHYSICAL THERAPY	303,707	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,274	0		67.00
69.00	06900	ELECTROCARDIOLOGY	67,120	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,300	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,593	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	503,471	326		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	0		88.00
88.01	08801	RHC - GIRARD	0	0		88.01
90.00	09000	CLINIC	589,905	0		90.00
91.00	09100	EMERGENCY	719,668	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	90,350	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,615,238	326		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,615,238	326		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D Part V Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.236694	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.854110	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.272227	0	0	0	0	54.00
60.00	06000	LABORATORY	0.281245	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.657498	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.543279	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.369440	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.179609	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.475040	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.862887	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.715672	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0.000000				0	88.00
88.01	08801	RHC - GIRARD	0.000000				0	88.01
90.00	09000	CLINIC	1.206658	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.497210	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.613986	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D Part V Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	0		88.00
88.01	08801	RHC - GIRARD	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D-1 | Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,739	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,031	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)	887	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	649	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)	951	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	15	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)	93	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	729	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)	649	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)	951	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	138.58	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,508,924	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,018	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	12,888	25.00
26.00	Total swing-bed cost (see instructions)	2,139,738	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,369,186	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)	1,369,186	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)	1,328.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	968,127	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)	968,127	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D-1 | Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	541,266	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,509,393	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	861,885	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,262,947	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,124,832	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)	144	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,328.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	191,235	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D-1 | Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	975,733	1,369,186	0.712637	191,235	136,281	90.00
91.00	Nursing School cost	0	1,369,186	0.000000	191,235	0	91.00
92.00	Allied health cost	0	1,369,186	0.000000	191,235	0	92.00
93.00	All other Medical Education	0	1,369,186	0.000000	191,235	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D-3 | Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		575,980		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.236694	3,150	3,896	50.00
53.00	05300	ANESTHESIOLOGY	0.854110	994	849	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.272227	291,757	79,424	54.00
60.00	06000	LABORATORY	0.281245	307,423	86,461	60.00
65.00	06500	RESPIRATORY THERAPY	0.657498	77,869	51,199	65.00
66.00	06600	PHYSICAL THERAPY	0.543279	69,798	37,920	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.369440	28,777	10,631	67.00
69.00	06900	ELECTROCARDIOLOGY	0.179609	21,004	3,773	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.475040	151,383	71,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.862887	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.715672	265,763	190,199	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0.000000		0	88.00
88.01	08801	RHC - GIRARD	0.000000		0	88.01
90.00	09000	CLINIC	1.206658	0	0	90.00
91.00	09100	EMERGENCY	0.497210	10,059	5,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.613986	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,227,977	541,266	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)		1,227,977		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet D-3 | Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.236694	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.854110	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.272227	109,776	29,884	54.00
60.00	06000	LABORATORY	0.281245	198,199	55,742	60.00
65.00	06500	RESPIRATORY THERAPY	0.657498	66,851	43,954	65.00
66.00	06600	PHYSICAL THERAPY	0.543279	418,290	227,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.369440	429,605	158,713	67.00
69.00	06900	ELECTROCARDIOLOGY	0.179609	4,956	890	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.475040	141,055	67,007	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.862887	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.715672	409,081	292,768	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0.000000		0	88.00
88.01	08801	RHC - GIRARD	0.000000		0	88.01
90.00	09000	CLINIC	1.206658	0	0	90.00
91.00	09100	EMERGENCY	0.497210	7,785	3,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.613986	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,785,598	880,077	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)		1,785,598		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2013 To 07/31/2014	Worksheet E Part B Date/Time Prepared: 12/19/2014 5:05 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,615,564	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,615,564	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 Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,671,720	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	53,037	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,805,935	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,812,748	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,812,748	30.00
31.00	Primary payer payments	2,019	31.00
32.00	Subtotal (line 30 minus line 31)	3,810,729	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	378,894	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	333,427	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	361,105	36.00
37.00	Subtotal (see instructions)	4,144,156	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,144,156	40.00
40.01	Sequestration adjustment (see instructions)	82,883	40.01
41.00	Interim payments	3,734,133	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	327,140	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 12/19/2014 5:05 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		1,056,224		3,469,110	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	03/14/2014	58,911	03/14/2014	8,018	3.01
3.02		07/31/2014	46,060	07/31/2014	346,916	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	07/31/2014	74,865	07/31/2014	89,911	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)		30,106		265,023	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)		1,086,330		3,734,133	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		254,019		327,140	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,340,349		4,061,273	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 12/19/2014 5:05 pm

Component CCN: 14Z347 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,474,180		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	03/14/2014	158,759		0	3.01
3.02		07/31/2014	196,527		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		355,286		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,829,466		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		84,433		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,913,899		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141347	Period: From 08/01/2013 To 07/31/2014	Worksheet E-1 Part II Date/Time Prepared: 12/19/2014 5:05 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	287	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	729	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	887	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	31,230,501	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	553,260	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141347 Component CCN: 14Z347	Period: From 08/01/2013 To 07/31/2014	Worksheet E-2 Date/Time Prepared: 12/19/2014 5:05 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,146,080	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	888,878	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	1,600	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)	3,034,958	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,034,958	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)	3,034,958	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	61,592	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)	2,973,366	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
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)	2,973,366	0	19.00
19.01	Sequestration adjustment (see instructions)	59,467	0	19.01
20.00	Interim payments	2,829,466	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	84,433	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2013 To 07/31/2014	Worksheet E-3 Part V Date/Time Prepared: 12/19/2014 5:05 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,509,393	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,509,393	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,524,487	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)	1,524,487	19.00
20.00	Deductibles (exclude professional component)	194,328	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,330,159	22.00
23.00	Coinsurance	1,776	23.00
24.00	Subtotal (line 22 minus line 23)	1,328,383	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	44,682	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	39,320	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,025	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,367,703	28.00
29.00	-14011	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,367,703	30.00
30.01	Sequestration adjustment (see instructions)	27,354	30.01
31.00	Interim payments	1,086,330	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	254,019	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet G | Date/Time Prepared: 12/19/2014 5:05 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	4,629,580	0	0	0	1.00
2.00	Temporary investments	104,916	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,978,148	0	0	0	4.00
5.00	Other receivable	516,239	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-874,000	0	0	0	6.00
7.00	Inventory	173,520	0	0	0	7.00
8.00	Prepaid expenses	214,542	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,742,945	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	517,172	0	0	0	12.00
13.00	Land improvements	1,314,634	0	0	0	13.00
14.00	Accumulated depreciation	-294,307	0	0	0	14.00
15.00	Buildings	19,812,583	0	0	0	15.00
16.00	Accumulated depreciation	-4,657,180	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,120,022	0	0	0	23.00
24.00	Accumulated depreciation	-2,957,587	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	1,188,306	0	0	0	27.00
28.00	Accumulated depreciation	-741,548	0	0	0	28.00
29.00	Minor equipment-nondepreciable	34,730	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,336,825	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,375,934	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,893,803	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,269,737	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,349,507	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	659,061	0	0	0	37.00
38.00	Salaries, wages, and fees payable	661,877	0	0	0	38.00
39.00	Payroll taxes payable	9,881	0	0	0	39.00
40.00	Notes and loans payable (short term)	454,019	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	203,060	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,987,898	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,828,816	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,198,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	19,026,816	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	21,014,714	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,334,793				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)	13,334,793	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,349,507	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet G-1 | Date/Time Prepared: 12/19/2014 5:05 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		13,418,103		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-143,298				2.00
3.00	Total (sum of line 1 and line 2)		13,274,805		0		3.00
4.00	INCREASE IN PERM RESTRICTED	59,988		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)		59,988		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,334,793		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,334,793		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	INCREASE IN PERM RESTRICTED		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			0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/19/2014 5:05 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,040,748		1,040,748	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	703,600		703,600	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,744,348		1,744,348	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,744,348		1,744,348	17.00
18.00	Ancillary services	3,395,724	0	3,395,724	18.00
19.00	Outpatient services	0	27,957,583	27,957,583	19.00
20.00	RHC - CARLINVILLE	0	436,288	436,288	20.00
20.01	RHC - GIRARD	0	157,115	157,115	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,140,072	28,550,986	33,691,058	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,341,452		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,341,452		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet G-3 | Date/Time Prepared: 12/19/2014 5:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,691,058	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,031,344	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,659,714	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,341,452	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-681,738	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	53,706	6.00
7.00	Income from investments	56,815	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	16,226	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	53,837	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	20,874	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	339,955	24.01
24.02	PHYSICAL THERAPY - NON PATIENTS	0	24.02
24.03	OTHER	61,744	24.03
24.04	CONTRIBUTIONS FOR LONG LIVED ASSETS	172,745	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	82,650	24.05
24.06	GRANTS	37,283	24.06
25.00	Total other income (sum of lines 6-24)	895,835	25.00
26.00	Total (line 5 plus line 25)	214,097	26.00
27.00	LOSS FROM DISPOSAL	357,395	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	357,395	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-143,298	29.00

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

Provider CCN: 141347 Component CCN: 148530 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-1 | Date/Time Prepared: 12/19/2014 5:05 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	156,047	6,625	162,672	-52,016	110,656	1.00
2.00	Physician Assistant	59,738	0	59,738	-19,913	39,825	2.00
3.00	Nurse Practitioner	0	0	0	0	0	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	197,968	134,116	332,084	-74,687	257,397	9.00
10.00	Subtotal (sum of lines 1-9)	413,753	140,741	554,494	-146,616	407,878	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 11-13)	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 15-20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	413,753	140,741	554,494	-146,616	407,878	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	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)	413,753	140,741	554,494	-146,616	407,878	32.00

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

Provider CCN: 141347 | Component CCN: 148530 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-1 | Date/Time Prepared: 12/19/2014 5:05 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	110,656		1.00
2.00	Physician Assistant	0	39,825		2.00
3.00	Nurse Practitioner	0	0		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	257,397		9.00
10.00	Subtotal (sum of lines 1-9)	0	407,878		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 11-13)	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 15-20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	407,878		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	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	407,878		32.00

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

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-1 | Date/Time Prepared: 12/19/2014 5:05 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	85,510	0	85,510	-46,318	39,192	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	92,590	110,466	203,056	-108,037	95,019	9.00
10.00	Subtotal (sum of lines 1-9)	178,100	110,466	288,566	-154,355	134,211	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 11-13)	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 15-20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	178,100	110,466	288,566	-154,355	134,211	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	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)	178,100	110,466	288,566	-154,355	134,211	32.00

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

Provider CCN: 141347 | Component CCN: 148532 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-1 | Date/Time Prepared: 12/19/2014 5:05 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	39,192		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	95,019		9.00
10.00	Subtotal (sum of lines 1-9)	0	134,211		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 11-13)	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 15-20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	134,211		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	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	134,211		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141347 | Component CCN: 148530 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-2 | Date/Time Prepared: 12/19/2014 5:05 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.59	1,958	4,200	2,478		1.00
2.00	Physician Assistant	0.42	755	2,100	882		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	1.01	2,713		3,360	3,360	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 4-7)	1.01	2,713			3,360	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					407,878	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					407,878	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					156,950	15.00
16.00	Total overhead (sum of lines 14 and 15)					156,950	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					156,950	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					156,950	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					564,828	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141347 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-2

Component CCN: 148532 | Date/Time Prepared: 12/19/2014 5:05 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.42	765	2,100	882		3.00
4.00	Subtotal (sum of lines 1-3)	0.42	765		882	882	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 4-7)	0.42	765			882	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					134,211	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					134,211	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					58,279	15.00
16.00	Total overhead (sum of lines 14 and 15)					58,279	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					58,279	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					58,279	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					192,490	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141347 Component CCN: 148530	Period: From 08/01/2013 To 07/31/2014	Worksheet M-3 Date/Time Prepared: 12/19/2014 5:05 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		564,828	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		168	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		564,660	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,360	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,360	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		168.05	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	168.05	168.05	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	770	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	129,399	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		129,399	16.00
16.01	Total program charges (see instructions)(from contractor's records)		84,148	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,258	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,935	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.)		98,814	16.04
16.05	Total program cost (see instructions)		100,749	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,946	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,789	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		100,749	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		69	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		100,818	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
26.00	Net reimbursable amount (see instructions)		100,818	26.00
26.01	Sequestration adjustment (see instructions)		2,016	26.01
27.00	Interim payments		91,307	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		7,495	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141347 | Component CCN: 148532 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-3 | Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Rural Health Clinic (RHC) II | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		192,490	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		4	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		192,486	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		882	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		882	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		218.24	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	218.24	218.24	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	171	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	37,319	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		37,319	16.00
16.01	Total program charges (see instructions)(from contractor's records)		24,895	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		216	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		324	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.)		28,736	16.04
16.05	Total program cost (see instructions)		29,060	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,075	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,721	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		29,060	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		29,060	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
26.00	Net reimbursable amount (see instructions)		29,060	26.00
26.01	Sequestration adjustment (see instructions)		581	26.01
27.00	Interim payments		15,181	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		13,298	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141347 | Component CCN: 148530 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-4 | Date/Time Prepared: 12/19/2014 5:05 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	407,878	407,878	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000018	0.000280	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	7	114	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7	114	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	407,878	407,878	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	156,950	156,950	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000017	0.000279	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3	44	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	10	158	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	2	32	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	5.00	4.94	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	12	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	10	59	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		168	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		69	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141347 Component CCN: 148532	Period: From 08/01/2013 To 07/31/2014	Worksheet M-4 Date/Time Prepared: 12/19/2014 5:05 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	134,211	134,211	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000026	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	3	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	3	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	134,211	134,211	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	58,279	58,279	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000022	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	1	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	4	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	1	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	4.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		4	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141347 Component CCN: 148530

Period: From 08/01/2013 To 07/31/2014

Worksheet M-5

Date/Time Prepared: 12/19/2014 5:05 pm

Rural Health Clinic (RHC) I

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		91,307	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)		91,307	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		7,495	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		98,802	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2013 To 07/31/2014 | Worksheet M-5 | Date/Time Prepared: 12/19/2014 5:05 pm

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		15,181	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)		15,181	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		13,298	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		28,479	7.00

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