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 08/01/2015 To 07/31/2016	Worksheet S Parts I-III Date/Time Prepared: 12/22/2016 11:32 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 12/22/2016 Time: 11:32 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 08/01/2015 and ending 07/31/2016 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	-24,808	15,905	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	-83,005	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RHC - CARLINVILLE I	0		23,404		0	10.00
10.01	RHC - GIRARD II	0		2,916		0	10.01
200.00	Total	0	-107,813	42,225	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 08/01/2015 To 07/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 12/22/2016 8:49 am

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CARLINVILLE AREA HOSPITAL	141347	99914	1	07/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CARLINVILLE AREA HOSPITAL SWING BED	14Z347	99914		07/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CARLINVILLE RHC	148530	99914		11/25/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	GIRARD RHC	148532	99914		02/12/2014	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	08/01/2015	07/31/2016	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 §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 12/22/2016 8:49 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 12/22/2016 8:49 am

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	173,234	0	0	118.01

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		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141347	Period: From 08/01/2015 To 07/31/2016	Worksheet S-2 Part I Date/Time Prepared: 12/22/2016 8:49 am

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 12/22/2016 8:49 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/01/2016	Y	11/01/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 12/22/2016 8:49 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	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 08/01/2015 To 07/31/2016	Worksheet S-2 Part II Date/Time Prepared: 12/22/2016 8:49 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CFO		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 12/22/2016 8:49 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	33,744.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	33,744.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	33,744.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	88.00				0	26.00
26.01	RHC - GIRARD	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 12/22/2016 8:49 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,063	89	1,406			1.00
2.00	HMO and other (see instructions)	112	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	1,954	0	2,096			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	119			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,017	89	3,621			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)	3,017	89	3,621	0.00	134.06	14.00
15.00	CAH visits	11,601	3,350	22,487			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	1,293	869	4,420	0.00	9.45	26.00
26.01	RHC - GIRARD	355	559	1,480	0.00	3.30	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	146.81	27.00
28.00	Observation Bed Days		51	335			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 08/01/2015 To 07/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 12/22/2016 8:49 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	363	31	492	1.00
2.00	HMO and other (see instructions)			28	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	363	31	492	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	0.00					26.00
26.01	RHC - GIRARD	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141347 Component CCN: 148530 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-8 | Date/Time Prepared: 12/22/2016 8:49 am

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

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

Provider CCN: 141347
Component CCN: 148530

Period:
From 08/01/2015
To 07/31/2016

Worksheet S-8

Date/Time Prepared:
12/22/2016 8:49 am

Rural Health Clinic (RHC) I

Cost

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

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

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-8 Date/Time Prepared: 12/22/2016 8:49 am

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

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

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

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

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

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

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

Provider CCN: 141347
Component CCN: 148532
Period: From 08/01/2015 To 07/31/2016
Worksheet S-8
Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet S-10 | Date/Time Prepared: 12/22/2016 8:49 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.474875	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,286,430	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	1,555,375	5.00
6.00	Medicaid charges	7,855,827	6.00
7.00	Medicaid cost (line 1 times line 6)	3,730,536	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	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	28,659	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	326,098	0	326,098	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	154,856	0	154,856	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)	154,856	0	154,856	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)	770,223	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	253,859	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	516,364	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	245,208	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	400,064	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	400,064	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A | Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,541,369	1,541,369	809,174	2,350,543	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		605,196	605,196	15,079	620,275	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,176,685	2,176,685	0	2,176,685	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,322,538	2,618,236	3,940,774	-2,627	3,938,147	5.00
7.00	00700	OPERATION OF PLANT	222,122	493,208	715,330	0	715,330	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,163	73,163	0	73,163	8.00
9.00	00900	HOUSEKEEPING	238,641	43,049	281,690	0	281,690	9.00
10.00	01000	DIETARY	161,989	214,965	376,954	0	376,954	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	316,576	19,372	335,948	0	335,948	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144,644	70,253	214,897	0	214,897	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	173,580	1,288	174,868	0	174,868	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	954,064	263,020	1,217,084	0	1,217,084	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	210,550	459,713	670,263	0	670,263	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	448,664	778,001	1,226,665	3,635	1,230,300	54.00
60.00	06000	LABORATORY	595,663	603,886	1,199,549	0	1,199,549	60.00
65.00	06500	RESPIRATORY THERAPY	321,739	116,777	438,516	0	438,516	65.00
66.00	06600	PHYSICAL THERAPY	696,846	141,235	838,081	0	838,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,797	23,189	181,986	0	181,986	67.00
69.00	06900	ELECTROCARDIOLOGY	66,544	58,680	125,224	0	125,224	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	82,173	143,668	225,841	0	225,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,100	48,100	0	48,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	207,187	968,546	1,175,733	0	1,175,733	73.00
76.00	03550	BEHAVORIAL HEALTH	79,721	59,596	139,317	0	139,317	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	629,731	198,475	828,206	-62,855	765,351	88.00
88.01	08801	RHC - GIRARD	196,673	46,619	243,292	-6,637	236,655	88.01
90.00	09000	CLINIC	185,798	252,812	438,610	0	438,610	90.00
91.00	09100	EMERGENCY	1,073,596	1,609,113	2,682,709	0	2,682,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		755,769	755,769	-755,769	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,487,836	14,383,983	22,871,819	0	22,871,819	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	105,750	105,750	0	105,750	194.00
194.01	07951	FUND DEVELOPMENT	11,851	2,489	14,340	0	14,340	194.01
200.00		TOTAL (SUM OF LINES 118-199)	8,499,687	14,492,222	22,991,909	0	22,991,909	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A | Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-128,425	2,222,118		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-79,491	540,784		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,176,685		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-278,315	3,659,832		5.00
7.00	00700	OPERATION OF PLANT	-10	715,320		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,163		8.00
9.00	00900	HOUSEKEEPING	0	281,690		9.00
10.00	01000	DIETARY	-65,096	311,858		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	335,948		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,156	208,741		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	174,868		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,217,084		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-110,165	560,098		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-22,681	1,207,619		54.00
60.00	06000	LABORATORY	-300	1,199,249		60.00
65.00	06500	RESPIRATORY THERAPY	-33,271	405,245		65.00
66.00	06600	PHYSICAL THERAPY	-963	837,118		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	181,986		67.00
69.00	06900	ELECTROCARDIOLOGY	-44,610	80,614		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	225,841		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,100		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-34,578	1,141,155		73.00
76.00	03550	BEHAVORIAL HEALTH	0	139,317		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	765,351		88.00
88.01	08801	RHC - GIRARD	0	236,655		88.01
90.00	09000	CLINIC	-30,277	408,333		90.00
91.00	09100	EMERGENCY	-1,466,376	1,216,333		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,300,714	20,571,105		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	105,750		194.00
194.01	07951	FUND DEVELOPMENT	0	14,340		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,300,714	20,691,195		200.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A-6 | Date/Time Prepared: 12/22/2016 8:49 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASSIFY RECRUITMENT EXPENSES					
1.00	RHC - CARLINVILLE	88.00	0	8,396		1.00
	TOTALS		0	8,396		
	B - RECLASS PHYSICIAN SALARY EXPENSE					
1.00	RHC - GIRARD	88.01	16,000	0		1.00
	TOTALS		16,000	0		
	C - INSURANCE EXPENSE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	72,119		1.00
	TOTALS		0	72,119		
	E - INTEREST EXPENSE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,635		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	752,134		2.00
	TOTALS		0	755,769		
	L - RECLASS RHC ADMIN SALARIES TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	77,888	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		77,888	0		
500.00	Grand Total: Increases		93,888	836,284		500.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A-6 | Date/Time Prepared: 12/22/2016 8:49 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASSIFY RECRUITMENT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,396	0		1.00
	TOTALS		0	8,396			
	B - RECLASS PHYSICIAN SALARY EXPENSE						
1.00	RHC - CARLINVILLE	88.00	16,000	0	0		1.00
	TOTALS		16,000	0			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	72,119	0		1.00
	TOTALS		0	72,119			
	E - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	755,769	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	755,769			
	L - RECLASS RHC ADMIN SALARIES TO ADMIN						
1.00	RHC - CARLINVILLE	88.00	55,251	0	0		1.00
2.00	RHC - GIRARD	88.01	22,637	0	0		2.00
	TOTALS		77,888	0			
500.00	Grand Total: Decreases		93,888	836,284			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 12/22/2016 8:49 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	517,171	0	0	0	0	1.00
2.00	Land Improvements	1,314,635	996,416	0	996,416	0	2.00
3.00	Buildings and Fixtures	24,215,994	1,335,133	0	1,335,133	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,271,000	1,050,708	0	1,050,708	0	6.00
7.00	HIT designated Assets	1,180,327	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,499,127	3,382,257	0	3,382,257	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,499,127	3,382,257	0	3,382,257	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	517,171	0	1.00
2.00	Land Improvements	2,311,051	0	2.00
3.00	Buildings and Fixtures	25,551,127	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,321,708	0	6.00
7.00	HIT designated Assets	1,180,327	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,881,384	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,881,384	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 12/22/2016 8:49 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,541,369	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	605,196	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,146,565	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	1,541,369		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	605,196		2.00
3.00	Total (sum of lines 1-2)	0	2,146,565		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A-7 Part III | Date/Time Prepared: 12/22/2016 8:49 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	28,379,349	0	28,379,349	0.790921	57,040	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,502,035	0	7,502,035	0.209079	15,079	2.00
3.00	Total (sum of lines 1-2)	35,881,384	0	35,881,384	1.000000	72,119	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	57,040	2,165,078	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	15,079	525,705	0	2.00
3.00	Total (sum of lines 1-2)	0	0	72,119	2,690,783	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	57,040	0	0	2,222,118	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	15,079	0	0	540,784	2.00
3.00	Total (sum of lines 1-2)	0	72,119	0	0	2,762,902	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A-8 | Date/Time Prepared: 12/22/2016 8:49 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-29,924	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	-964	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,208	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	-1,574,724			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	-63,812	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	-34,578	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,156	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	B	-9,252	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-79,491	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A-8 | Date/Time Prepared: 12/22/2016 8:49 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	DIETARY DISCOUNTS	B	-1,284	DIETARY	10.00	0	33.00
33.01	RADIOLOGY DISCOUNTS	B	-22,681	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	PT PROF FEES	B	-363	PHYSICAL THERAPY	66.00	0	33.02
33.03	PREVIOUS DEBT ISSUANCE COSTS	A	43,119	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.03
33.04	CONTRACT LAB	B	-300	LABORATORY	60.00	0	33.04
33.05	SUPPLIES	B	-1,817	OPERATING ROOM	50.00	0	33.05
33.06	AHA & IHA DUES	A	-7,700	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PLANT OPERATION DISCOUNTS	B	-10	OPERATION OF PLANT	7.00	0	33.07
36.00			0		0.00	0	36.00
37.00			0		0.00	0	37.00
39.00	MED STAFF RELATIONS	A	-12,284	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00			0		0.00	0	40.00
41.00	NON-PATIENT REVENUE	B	-2,085	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING	A	-243,843	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	TELEPHONE DEPRECIATION	A	-1,798	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-4,200	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-30,277	CLINIC	90.00	0	44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,869	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	INSURANCE PROCEEDS	A	-1,624	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05	MOB BUILDING RENT	B	-130,570	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.05
44.06			0		0.00	0	44.06
44.07	PROPERTY TAX POGUE BUILDING	A	-474	ADMINISTRATIVE & GENERAL	5.00	0	44.07
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03	REVIEW COSTS	A	-64	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	DAISY PROGRAM	B	-600	PHYSICAL THERAPY	66.00	0	45.04
45.05	EKG PROFESSIONAL FEES	A	-44,610	ELECTROCARDIOLOGY	69.00	0	45.05
45.06	SLEEP STUDY PROFESSONAL FEES	A	-33,271	RESPIRATORY THERAPY	65.00	0	45.06
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.09			0		0.00	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,300,714				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 08/01/2015 To 07/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 12/22/2016 8:49 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,525,200	1,015,173	510,027	0	0	1.00
2.00	91.00	EMERGENCY	359,212	359,212	0	0	0	2.00
3.00	50.00	OPERATING ROOM	108,348	108,348	0	0	0	3.00
4.00	91.00	EMERGENCY	91,991	91,991	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,084,751	1,574,724	510,027		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	1,015,173		1.00
2.00	91.00	EMERGENCY	0	0	0	359,212		2.00
3.00	50.00	OPERATING ROOM	0	0	0	108,348		3.00
4.00	91.00	EMERGENCY	0	0	0	91,991		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	1,574,724		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/22/2016 8:49 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.57	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	260.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.49	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)	39.75	39.75	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)					20,727	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)					20,727	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)					20,727	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)					79.49	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					62,002	22.00
23.00	Total salary equivalency (see instructions)					62,002	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 08/01/2015 To 07/31/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/22/2016 8:49 am

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)	79.49	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)	62,002		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)	62,002		63.00
64.00	Total cost of outside supplier services (from your records)	16,235		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 08/01/2015 To 07/31/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/22/2016 8:49 am

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.57	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	602.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	62.41	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)	31.21	31.21	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		37,618	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)		37,618	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)		37,618	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)		62.41	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		48,680	22.00
23.00	Total salary equivalency (see instructions)		48,680	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

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		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	62.41	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)		48,680	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)		48,680	63.00
64.00	Total cost of outside supplier services (from your records)		40,184	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

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		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.57	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	313.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.33	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.67	37.67	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	23,597	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)	23,597	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	23,597	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)	75.33	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	58,757	22.00
23.00	Total salary equivalency (see instructions)	58,757	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

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		Occupational Therapy	Cost
		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.33	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)	58,757	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)	58,757	63.00
64.00	Total cost of outside supplier services (from your records)	20,670	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

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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	479.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.39	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)	36.20	36.20	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)					34,711	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)					34,711	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					34,711	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)					72.39	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					56,464	22.00
23.00	Total salary equivalency (see instructions)					56,464	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

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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)	72.39	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)	56,464	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)	56,464	63.00
64.00	Total cost of outside supplier services (from your records)	28,770	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 08/01/2015 To 07/31/2016 | Worksheet B Part I Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,222,118	2,222,118				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	540,784		540,784			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,176,685	0	0	2,176,685		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,659,832	472,046	104,959	358,636	4,595,473	5.00
7.00	00700	OPERATION OF PLANT	715,320	266,558	22,263	56,883	1,061,024	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,163	0	0	0	73,163	8.00
9.00	00900	HOUSEKEEPING	281,690	11,249	19	61,114	354,072	9.00
10.00	01000	DIETARY	311,858	43,305	17,610	41,484	414,257	10.00
11.00	01100	CAFETERIA	0	43,637	0	0	43,637	11.00
13.00	01300	NURSING ADMINISTRATION	335,948	7,147	657	81,072	424,824	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	208,741	32,238	4,908	37,042	282,929	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	174,868	2,382	36	44,452	221,738	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,217,084	338,000	38,542	244,326	1,837,952	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	560,098	158,626	54,564	53,920	827,208	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,207,619	106,514	177,584	114,898	1,606,615	54.00
60.00	06000	LABORATORY	1,199,249	44,421	9,761	152,543	1,405,974	60.00
65.00	06500	RESPIRATORY THERAPY	405,245	87,003	33,844	82,394	608,486	65.00
66.00	06600	PHYSICAL THERAPY	837,118	169,211	26,997	178,455	1,211,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,986	12,515	0	40,666	235,167	67.00
69.00	06900	ELECTROCARDIOLOGY	80,614	68,517	0	17,041	166,172	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	225,841	24,940	1,044	21,044	272,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,100	0	0	0	48,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,141,155	19,421	3,897	53,059	1,217,532	73.00
76.00	03550	BEHAVORIAL HEALTH	139,317	29,825	741	20,416	190,299	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	765,351	133,626	16,610	143,021	1,058,608	88.00
88.01	08801	RHC - GIRARD	236,655	0	0	48,666	285,321	88.01
90.00	09000	CLINIC	408,333	76,991	2,942	47,581	535,847	90.00
91.00	09100	EMERGENCY	1,216,333	66,587	23,476	274,937	1,581,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,571,105	2,214,759	540,454	2,173,650	20,560,381	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,519	20	0	5,539	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	105,750	0	0	0	105,750	194.00
194.01	07951	FUND DEVELOPMENT	14,340	1,840	310	3,035	19,525	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)	20,691,195	2,222,118	540,784	2,176,685	20,691,195	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet B Part I | Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,595,473					5.00
7.00	00700	OPERATION OF PLANT	302,932	1,363,956				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,889	0	94,052			8.00
9.00	00900	HOUSEKEEPING	101,091	10,342	0	465,505		9.00
10.00	01000	DIETARY	118,274	39,815	0	12,857	585,203	10.00
11.00	01100	CAFETERIA	12,459	40,120	0	12,955	311,518	11.00
13.00	01300	NURSING ADMINISTRATION	121,291	6,571	0	2,122	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80,779	29,640	0	9,571	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	63,308	2,190	0	707	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	524,751	310,762	49,406	100,347	273,685	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	236,175	145,842	6,816	47,094	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	458,703	97,930	7,927	31,623	0	54.00
60.00	06000	LABORATORY	401,418	40,841	0	13,188	0	60.00
65.00	06500	RESPIRATORY THERAPY	173,728	79,991	522	25,830	0	65.00
66.00	06600	PHYSICAL THERAPY	345,974	155,574	5,936	50,237	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,142	11,507	0	3,716	0	67.00
69.00	06900	ELECTROCARDIOLOGY	47,444	62,995	0	20,342	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,907	22,930	0	7,404	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,733	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	347,616	17,856	0	5,766	0	73.00
76.00	03550	BEHAVORIAL HEALTH	54,332	27,422	0	8,855	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	302,242	122,857	14	43,566	0	88.00
88.01	08801	RHC - GIRARD	81,462	0	0	24,514	0	88.01
90.00	09000	CLINIC	152,989	70,786	0	22,858	0	90.00
91.00	09100	EMERGENCY	451,485	61,220	23,431	19,769	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,558,124	1,357,191	94,052	463,321	585,203	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,581	5,074	0	1,638	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	30,193	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	5,575	1,691	0	546	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)	4,595,473	1,363,956	94,052	465,505	585,203	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet B Part I | Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	420,689					11.00
13.00	01300	NURSING ADMINISTRATION	14,911	569,719				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,042	0	419,961			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,402	11,363	4,702	308,410		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,597	257,120	27,198	0	3,480,818	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,042	43,994	17,310	0	1,341,481	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	308,410	308,410	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,870	0	108,843	0	2,349,511	54.00
60.00	06000	LABORATORY	48,994	0	84,094	0	1,994,509	60.00
65.00	06500	RESPIRATORY THERAPY	18,462	0	11,856	0	918,875	65.00
66.00	06600	PHYSICAL THERAPY	38,675	0	35,837	0	1,844,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,846	0	8,882	0	336,260	67.00
69.00	06900	ELECTROCARDIOLOGY	5,681	0	8,579	0	311,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,574	0	10,491	0	399,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	800	0	62,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,876	33,242	36,038	0	1,670,926	73.00
76.00	03550	BEHAVORIAL HEALTH	9,515	24,564	1,528	0	316,515	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	6,779	0	1,534,066	88.00
88.01	08801	RHC - GIRARD	0	0	2,537	0	393,834	88.01
90.00	09000	CLINIC	16,710	43,136	6,622	0	848,948	90.00
91.00	09100	EMERGENCY	60,545	156,300	47,865	0	2,401,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	419,742	569,719	419,961	308,410	20,513,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	13,832	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	135,943	194.00
194.01	07951	FUND DEVELOPMENT	947	0	0	0	28,284	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)	420,689	569,719	419,961	308,410	20,691,195	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet B Part I Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,480,818		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,341,481		50.00
53.00	05300	ANESTHESIOLOGY	0	308,410		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,349,511		54.00
60.00	06000	LABORATORY	0	1,994,509		60.00
65.00	06500	RESPIRATORY THERAPY	0	918,875		65.00
66.00	06600	PHYSICAL THERAPY	0	1,844,014		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	336,260		67.00
69.00	06900	ELECTROCARDIOLOGY	0	311,213		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	399,175		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	62,633		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,670,926		73.00
76.00	03550	BEHAVORIAL HEALTH	0	316,515		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	1,534,066		88.00
88.01	08801	RHC - GIRARD	0	393,834		88.01
90.00	09000	CLINIC	0	848,948		90.00
91.00	09100	EMERGENCY	0	2,401,948		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	20,513,136		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	13,832		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	135,943		194.00
194.01	07951	FUND DEVELOPMENT	0	28,284		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	20,691,195		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet B Part II Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,686	472,046	104,959	612,691	0	5.00
7.00	00700	OPERATION OF PLANT	0	266,558	22,263	288,821	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	11,249	19	11,268	0	9.00
10.00	01000	DIETARY	1,591	43,305	17,610	62,506	0	10.00
11.00	01100	CAFETERIA	0	43,637	0	43,637	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,147	657	7,804	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,238	4,908	37,146	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,382	36	2,418	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,555	338,000	38,542	390,097	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	222,665	158,626	54,564	435,855	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,368	106,514	177,584	302,466	0	54.00
60.00	06000	LABORATORY	28,318	44,421	9,761	82,500	0	60.00
65.00	06500	RESPIRATORY THERAPY	16,845	87,003	33,844	137,692	0	65.00
66.00	06600	PHYSICAL THERAPY	0	169,211	26,997	196,208	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,515	0	12,515	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	68,517	0	68,517	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,940	1,044	25,984	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	86,245	19,421	3,897	109,563	0	73.00
76.00	03550	BEHAVORIAL HEALTH	0	29,825	741	30,566	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	8,576	133,626	16,610	158,812	0	88.00
88.01	08801	RHC - GIRARD	24,642	0	0	24,642	0	88.01
90.00	09000	CLINIC	0	76,991	2,942	79,933	0	90.00
91.00	09100	EMERGENCY	0	66,587	23,476	90,063	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	456,491	2,214,759	540,454	3,211,704	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,519	20	5,539	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	1,840	310	2,150	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)	456,491	2,222,118	540,784	3,219,393	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet B Part II | Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	612,691					5.00
7.00	00700	OPERATION OF PLANT	40,388	329,209				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,785	0	2,785			8.00
9.00	00900	HOUSEKEEPING	13,478	2,496	0	27,242		9.00
10.00	01000	DIETARY	15,769	9,610	0	752	88,637	10.00
11.00	01100	CAFETERIA	1,661	9,684	0	758	47,184	11.00
13.00	01300	NURSING ADMINISTRATION	16,171	1,586	0	124	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,770	7,154	0	560	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,440	529	0	41	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,969	75,005	1,463	5,873	41,453	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,488	35,201	202	2,756	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,156	23,637	235	1,851	0	54.00
60.00	06000	LABORATORY	53,518	9,858	0	772	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,162	19,307	15	1,512	0	65.00
66.00	06600	PHYSICAL THERAPY	46,126	37,550	176	2,940	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,952	2,777	0	217	0	67.00
69.00	06900	ELECTROCARDIOLOGY	6,325	15,205	0	1,190	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,387	5,534	0	433	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,831	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,345	4,310	0	337	0	73.00
76.00	03550	BEHAVORIAL HEALTH	7,244	6,619	0	518	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	40,296	29,653	0	2,550	0	88.00
88.01	08801	RHC - GIRARD	10,861	0	0	1,435	0	88.01
90.00	09000	CLINIC	20,397	17,085	0	1,338	0	90.00
91.00	09100	EMERGENCY	60,193	14,776	694	1,157	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	607,712	327,576	2,785	27,114	88,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	211	1,225	0	96	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	4,025	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	743	408	0	32	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)	612,691	329,209	2,785	27,242	88,637	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet B Part II | Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	102,924					11.00
13.00	01300	NURSING ADMINISTRATION	3,648	29,333				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,169	0	59,799			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,077	585	669	13,759		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,367	13,238	3,872		625,337	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,169	2,265	2,464		514,400	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,265	0	15,509		414,119	54.00
60.00	06000	LABORATORY	11,987	0	11,971		170,606	60.00
65.00	06500	RESPIRATORY THERAPY	4,517	0	1,688		187,893	65.00
66.00	06600	PHYSICAL THERAPY	9,462	0	5,102		297,564	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,409	0	1,264		28,134	67.00
69.00	06900	ELECTROCARDIOLOGY	1,390	0	1,221		93,848	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,853	0	1,494		45,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	114		1,945	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,150	1,712	5,130		170,547	73.00
76.00	03550	BEHAVORIAL HEALTH	2,328	1,265	218		48,758	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	965		232,276	88.00
88.01	08801	RHC - GIRARD	0	0	361		37,299	88.01
90.00	09000	CLINIC	4,088	2,221	943		126,005	90.00
91.00	09100	EMERGENCY	14,813	8,047	6,814		196,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	102,692	29,333	59,799	0	3,190,973	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		7,071	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		4,025	194.00
194.01	07951	FUND DEVELOPMENT	232	0	0		3,565	194.01
200.00		Cross Foot Adjustments				13,759	13,759	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	102,924	29,333	59,799	13,759	3,219,393	202.00

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		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	625,337		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	514,400		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	414,119		54.00
60.00	06000	LABORATORY	0	170,606		60.00
65.00	06500	RESPIRATORY THERAPY	0	187,893		65.00
66.00	06600	PHYSICAL THERAPY	0	297,564		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28,134		67.00
69.00	06900	ELECTROCARDIOLOGY	0	93,848		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,685		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,945		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	170,547		73.00
76.00	03550	BEHAVORIAL HEALTH	0	48,758		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	232,276		88.00
88.01	08801	RHC - GIRARD	0	37,299		88.01
90.00	09000	CLINIC	0	126,005		90.00
91.00	09100	EMERGENCY	0	196,557		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,190,973		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	7,071		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	4,025		194.00
194.01	07951	FUND DEVELOPMENT	0	3,565		194.01
200.00		Cross Foot Adjustments	0	13,759		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	3,219,393		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet B-1 | Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	73,685					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		490,386				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,499,687			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,653	95,177	1,400,426	-4,595,473	16,095,722	5.00
7.00	00700	OPERATION OF PLANT	8,839	20,188	222,122	0	1,061,024	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	73,163	8.00
9.00	00900	HOUSEKEEPING	373	17	238,641	0	354,072	9.00
10.00	01000	DIETARY	1,436	15,969	161,989	0	414,257	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	43,637	11.00
13.00	01300	NURSING ADMINISTRATION	237	596	316,576	0	424,824	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	4,451	144,644	0	282,929	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	33	173,580	0	221,738	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	34,950	954,064	0	1,837,952	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	49,479	210,550	0	827,208	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	161,034	448,664	0	1,606,615	54.00
60.00	06000	LABORATORY	1,473	8,851	595,663	0	1,405,974	60.00
65.00	06500	RESPIRATORY THERAPY	2,885	30,690	321,739	0	608,486	65.00
66.00	06600	PHYSICAL THERAPY	5,611	24,481	696,846	0	1,211,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	415	0	158,797	0	235,167	67.00
69.00	06900	ELECTROCARDIOLOGY	2,272	0	66,544	0	166,172	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	947	82,173	0	272,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	48,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	3,534	207,187	0	1,217,532	73.00
76.00	03550	BEHAVORIAL HEALTH	989	672	79,721	0	190,299	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	4,431	15,062	558,480	0	1,058,608	88.00
88.01	08801	RHC - GIRARD	0	0	190,036	0	285,321	88.01
90.00	09000	CLINIC	2,553	2,668	185,798	0	535,847	90.00
91.00	09100	EMERGENCY	2,208	21,288	1,073,596	0	1,581,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,441	490,087	8,487,836	-4,595,473	15,964,908	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	5,539	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	105,750	194.00
194.01	07951	FUND DEVELOPMENT	61	281	11,851	0	19,525	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)	2,222,118	540,784	2,176,685		4,595,473	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.156993	1.102772	0.256090		0.285509	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		612,691	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.038065	205.00

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		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	49,193					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,542				8.00
9.00	00900	HOUSEKEEPING	373	0	51,993			9.00
10.00	01000	DIETARY	1,436	0	1,436	33,658		10.00
11.00	01100	CAFETERIA	1,447	0	1,447	17,917	8,887	11.00
13.00	01300	NURSING ADMINISTRATION	237	0	237	0	315	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	0	1,069	0	360	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	93	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	65,424	11,208	15,741	2,104	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	9,025	5,260	0	360	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	10,497	3,532	0	800	54.00
60.00	06000	LABORATORY	1,473	0	1,473	0	1,035	60.00
65.00	06500	RESPIRATORY THERAPY	2,885	691	2,885	0	390	65.00
66.00	06600	PHYSICAL THERAPY	5,611	7,860	5,611	0	817	66.00
67.00	06700	OCCUPATIONAL THERAPY	415	0	415	0	208	67.00
69.00	06900	ELECTROCARDIOLOGY	2,272	0	2,272	0	120	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	0	827	0	160	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	272	73.00
76.00	03550	BEHAVORIAL HEALTH	989	0	989	0	201	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	4,431	18	4,866	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	2,738	0	0	88.01
90.00	09000	CLINIC	2,553	0	2,553	0	353	90.00
91.00	09100	EMERGENCY	2,208	31,027	2,208	0	1,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,949	124,542	51,749	33,658	8,867	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	0	183	0	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	0	61	0	20	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)	1,363,956	94,052	465,505	585,203	420,689	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.726628	0.755183	8.953224	17.386743	47.337572	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	329,209	2,785	27,242	88,637	102,924	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.692192	0.022362	0.523955	2.633460	11.581411	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet B-1 | Date/Time Prepared: 12/22/2016 8:49 am

		Cost Center Description	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	96,969				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43,196,893			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,934	483,677	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	43,763	2,797,557	0		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,488	1,780,512	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,195,321	0		54.00
60.00	06000	LABORATORY	0	8,649,859	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,219,536	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,686,227	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	913,606	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	882,472	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,079,121	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	82,257	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,658	3,706,801	0		73.00
76.00	03550	BEHAVORIAL HEALTH	4,181	157,189	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	697,274	0		88.00
88.01	08801	RHC - GIRARD	0	260,921	0		88.01
90.00	09000	CLINIC	7,342	681,174	0		90.00
91.00	09100	EMERGENCY	26,603	4,923,389	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,969	43,196,893	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	0	0	0		194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	569,719	419,961	308,410		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.875269	0.009722	3,084.100000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,333	59,799	13,759		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.302499	0.001384	137.590000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet C Part I Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,480,818		3,480,818	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,341,481		1,341,481	0	0	50.00
53.00	05300	ANESTHESIOLOGY	308,410		308,410	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,349,511		2,349,511	0	0	54.00
60.00	06000	LABORATORY	1,994,509		1,994,509	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	918,875	0	918,875	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,844,014	0	1,844,014	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,260	0	336,260	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	311,213		311,213	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	399,175		399,175	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,633		62,633	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,670,926		1,670,926	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	316,515		316,515	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	1,534,066		1,534,066	0	0	88.00
88.01	08801	RHC - GIRARD	393,834		393,834	0	0	88.01
90.00	09000	CLINIC	848,948		848,948	0	0	90.00
91.00	09100	EMERGENCY	2,401,948		2,401,948	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	302,435		302,435		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	20,815,571	0	20,815,571	0	0	200.00
201.00		Less Observation Beds	302,435		302,435		0	201.00
202.00		Total (see instructions)	20,513,136	0	20,513,136	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet C Part I Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,203,157		2,203,157			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,424	1,766,088	1,780,512	0.753424	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,361	482,316	483,677	0.637636	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,428	10,335,893	11,195,321	0.209865	0.000000	54.00
60.00	06000	LABORATORY	1,141,308	7,508,551	8,649,859	0.230583	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	422,578	796,958	1,219,536	0.753463	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	669,241	3,016,986	3,686,227	0.500244	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	572,479	341,127	913,606	0.368058	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	33,733	848,739	882,472	0.352660	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	608,578	470,543	1,079,121	0.369908	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	82,257	82,257	0.761431	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,887,884	1,818,917	3,706,801	0.450773	0.000000	73.00
76.00	03550	BEHAVORIAL HEALTH	0	157,189	157,189	2.013595	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	697,274	697,274			88.00
88.01	08801	RHC - GIRARD	0	260,921	260,921			88.01
90.00	09000	CLINIC	11,575	669,599	681,174	1.246301	0.000000	90.00
91.00	09100	EMERGENCY	129,316	4,794,073	4,923,389	0.487865	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	33,735	560,665	594,400	0.508807	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	8,588,797	34,608,096	43,196,893			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,588,797	34,608,096	43,196,893			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet C Part I Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D Part II Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	514,400	1,780,512	0.288906	10,997	3,177	50.00
53.00	05300	ANESTHESIOLOGY	0	483,677	0.000000	1,361	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	414,119	11,195,321	0.036990	492,786	18,228	54.00
60.00	06000	LABORATORY	170,606	8,649,859	0.019724	496,072	9,785	60.00
65.00	06500	RESPIRATORY THERAPY	187,893	1,219,536	0.154069	192,977	29,732	65.00
66.00	06600	PHYSICAL THERAPY	297,564	3,686,227	0.080723	92,341	7,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,134	913,606	0.030794	24,830	765	67.00
69.00	06900	ELECTROCARDIOLOGY	93,848	882,472	0.106347	22,194	2,360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,685	1,079,121	0.042335	252,775	10,701	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,945	82,257	0.023645	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,547	3,706,801	0.046009	606,910	27,923	73.00
76.00	03550	BEHAVORIAL HEALTH	48,758	157,189	0.310187	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	232,276	697,274	0.333120	0	0	88.00
88.01	08801	RHC - GIRARD	37,299	260,921	0.142951	0	0	88.01
90.00	09000	CLINIC	126,005	681,174	0.184982	0	0	90.00
91.00	09100	EMERGENCY	196,557	4,923,389	0.039923	16,192	646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	54,333	594,400	0.091408	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,619,969	40,993,736		2,209,435	110,771	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D Part IV Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	308,410	0	0	0	308,410	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	308,410	0	0	0	308,410	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D Part IV Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,780,512	0.000000	0.000000	10,997	50.00
53.00	05300	ANESTHESIOLOGY	0	483,677	0.637636	0.000000	1,361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,195,321	0.000000	0.000000	492,786	54.00
60.00	06000	LABORATORY	0	8,649,859	0.000000	0.000000	496,072	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,219,536	0.000000	0.000000	192,977	65.00
66.00	06600	PHYSICAL THERAPY	0	3,686,227	0.000000	0.000000	92,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	913,606	0.000000	0.000000	24,830	67.00
69.00	06900	ELECTROCARDIOLOGY	0	882,472	0.000000	0.000000	22,194	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,079,121	0.000000	0.000000	252,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	82,257	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,706,801	0.000000	0.000000	606,910	73.00
76.00	03550	BEHAVORIAL HEALTH	0	157,189	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	697,274	0.000000	0.000000	0	88.00
88.01	08801	RHC - GIRARD	0	260,921	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	681,174	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,923,389	0.000000	0.000000	16,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	594,400	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	40,993,736			2,209,435	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D Part IV | Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	868	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
76.00	03550	BEHAVORIAL HEALTH	0	0	0		76.00
		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)	868	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D Part V Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.753424	0	888,502	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.637636	0	265,320	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209865	0	4,181,714	0	0	54.00
60.00	06000	LABORATORY	0.230583	0	3,454,744	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.753463	0	349,478	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.500244	0	1,084,914	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368058	0	88,049	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.352660	0	447,449	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.369908	0	196,171	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761431	0	59,763	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450773	0	1,149,944	910	0	73.00
76.00	03550	BEHAVORIAL HEALTH	2.013595	0	150,360	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0.000000				0	88.00
88.01	08801	RHC - GIRARD	0.000000				0	88.01
90.00	09000	CLINIC	1.246301	0	475,550	0	0	90.00
91.00	09100	EMERGENCY	0.487865	0	1,707,034	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.508807	0	342,825	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	14,841,817	910	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	14,841,817	910	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D Part V Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	669,419	0	50.00
53.00	05300	ANESTHESIOLOGY	169,178	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	877,595	0	54.00
60.00	06000	LABORATORY	796,605	0	60.00
65.00	06500	RESPIRATORY THERAPY	263,319	0	65.00
66.00	06600	PHYSICAL THERAPY	542,722	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,407	0	67.00
69.00	06900	ELECTROCARDIOLOGY	157,797	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	72,565	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,505	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	518,364	410	73.00
76.00	03550	BEHAVORIAL HEALTH	302,764	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC - CARLINVILLE	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	88.01
90.00	09000	CLINIC	592,678	0	90.00
91.00	09100	EMERGENCY	832,802	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	174,432	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,048,152	410	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	6,048,152	410	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D Part V Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.753424	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.637636	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209865	0	0	0	0	54.00
60.00	06000	LABORATORY	0.230583	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.753463	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.500244	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368058	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.352660	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.369908	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761431	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450773	0	0	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	2.013595	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0.000000				0	88.00
88.01	08801	RHC - GIRARD	0.000000				0	88.01
90.00	09000	CLINIC	1.246301	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.487865	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.508807	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 08/01/2015 To 07/31/2016 | Worksheet D Part V Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	BEHAVORIAL HEALTH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	0		88.00
88.01	08801	RHC - GIRARD	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			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 08/01/2015 To 07/31/2016 | Worksheet D-1 | Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,956	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,741	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,406	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	751	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)	1,345	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	36	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)	83	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,063	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)	678	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)	1,276	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	138.58	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	142.73	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,480,818	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4,989	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)	11,847	25.00
26.00	Total swing-bed cost (see instructions)	1,909,063	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,571,755	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)	1,571,755	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)	902.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	959,655	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)	959,655	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D-1 | Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	810,500	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,770,155	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)	612,085	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,151,947	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,764,032	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	335	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	902.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	302,435	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D-1 | Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	625,337	3,480,818	0.179652	302,435	54,333	90.00
91.00	Nursing School cost	0	3,480,818	0.000000	302,435	0	91.00
92.00	Allied health cost	0	3,480,818	0.000000	302,435	0	92.00
93.00	All other Medical Education	0	3,480,818	0.000000	302,435	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D-3 | Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		914,180		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.753424	10,997	8,285	50.00
53.00	05300	ANESTHESIOLOGY	0.637636	1,361	868	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209865	492,786	103,419	54.00
60.00	06000	LABORATORY	0.230583	496,072	114,386	60.00
65.00	06500	RESPIRATORY THERAPY	0.753463	192,977	145,401	65.00
66.00	06600	PHYSICAL THERAPY	0.500244	92,341	46,193	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368058	24,830	9,139	67.00
69.00	06900	ELECTROCARDIOLOGY	0.352660	22,194	7,827	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.369908	252,775	93,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761431	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450773	606,910	273,579	73.00
76.00	03550	BEHAVORIAL HEALTH	2.013595	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0.000000		0	88.00
88.01	08801	RHC - GIRARD	0.000000		0	88.01
90.00	09000	CLINIC	1.246301	0	0	90.00
91.00	09100	EMERGENCY	0.487865	16,192	7,900	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.508807	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)		2,209,435	810,500	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,209,435		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet D-3 | Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.753424	3,027	2,281	50.00
53.00	05300	ANESTHESIOLOGY	0.637636	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209865	169,661	35,606	54.00
60.00	06000	LABORATORY	0.230583	405,095	93,408	60.00
65.00	06500	RESPIRATORY THERAPY	0.753463	158,943	119,758	65.00
66.00	06600	PHYSICAL THERAPY	0.500244	497,171	248,707	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368058	477,518	175,754	67.00
69.00	06900	ELECTROCARDIOLOGY	0.352660	5,194	1,832	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.369908	263,697	97,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761431	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450773	949,947	428,210	73.00
76.00	03550	BEHAVORIAL HEALTH	2.013595	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0.000000		0	88.00
88.01	08801	RHC - GIRARD	0.000000		0	88.01
90.00	09000	CLINIC	1.246301	10,593	13,202	90.00
91.00	09100	EMERGENCY	0.487865	7,040	3,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.508807	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)		2,947,886	1,219,737	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,947,886		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2015 To 07/31/2016	Worksheet E Part B Date/Time Prepared: 12/22/2016 8:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,048,562	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,048,562	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,109,048	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)	41,036	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,264,859	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,803,153	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,803,153	30.00
31.00	Primary payer payments	9	31.00
32.00	Subtotal (line 30 minus line 31)	3,803,144	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	338,361	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	219,935	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	325,574	36.00
37.00	Subtotal (see instructions)	4,023,079	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,023,079	40.00
40.01	Sequestration adjustment (see instructions)	80,462	40.01
41.00	Interim payments	3,926,712	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	15,905	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 08/01/2015 To 07/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 12/22/2016 8:49 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,974,841		4,539,808	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/31/2016	23,862	07/31/2016	153,964	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	07/28/2016	495,346	07/28/2016	767,060	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)		-471,484		-613,096	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)		1,503,357		3,926,712	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		15,905	6.01
6.02	SETTLEMENT TO PROGRAM		24,808		0	6.02
7.00	Total Medicare program liability (see instructions)		1,478,549		3,942,617	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 08/01/2015 To 07/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 12/22/2016 8:49 am

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		3,867,376		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	03/08/2016	34,474		0	3.50
3.51		07/28/2016	855,216		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)		-889,690		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)		2,977,686		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		83,005		0	6.02
7.00	Total Medicare program liability (see instructions)		2,894,681		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 08/01/2015 To 07/31/2016	Worksheet E-1 Part II Date/Time Prepared: 12/22/2016 8:49 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	492	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,063	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	112	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,406	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	43,196,893	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	326,098	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. 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 THE IPPS & 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 08/01/2015 To 07/31/2016	Worksheet E-2 Date/Time Prepared: 12/22/2016 8:49 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,781,672	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	1,231,934	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	1,954	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)	3,013,606	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,013,606	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)	3,013,606	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	59,850	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)	2,953,756	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,953,756	0	19.00
19.01	Sequestration adjustment (see instructions)	59,075	0	19.01
20.00	Interim payments	2,977,686	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)	-83,005	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2015 To 07/31/2016	Worksheet E-3 Part V Date/Time Prepared: 12/22/2016 8:49 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,770,155	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,770,155	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,787,857	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)	1,787,857	19.00
20.00	Deductibles (exclude professional component)	312,736	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,475,121	22.00
23.00	Coinsurance	322	23.00
24.00	Subtotal (line 22 minus line 23)	1,474,799	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	52,190	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,924	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,599	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,508,723	28.00
29.00	-14011	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,508,723	30.00
30.01	Sequestration adjustment (see instructions)	30,174	30.01
31.00	Interim payments	1,503,357	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)	-24,808	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 08/01/2015 To 07/31/2016 | Worksheet G | Date/Time Prepared: 12/22/2016 8:49 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,839,603	0	0	0	1.00
2.00	Temporary investments	138,838	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,902,943	0	0	0	4.00
5.00	Other receivable	16,178	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-532,000	0	0	0	6.00
7.00	Inventory	191,814	0	0	0	7.00
8.00	Prepaid expenses	239,899	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)	10,797,275	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	517,172	0	0	0	12.00
13.00	Land improvements	2,311,051	0	0	0	13.00
14.00	Accumulated depreciation	-496,148	0	0	0	14.00
15.00	Buildings	25,551,127	0	0	0	15.00
16.00	Accumulated depreciation	-10,548,433	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,321,707	0	0	0	23.00
24.00	Accumulated depreciation	-850,948	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,180,327	0	0	0	27.00
28.00	Accumulated depreciation	-853,277	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,132,578	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,945,030	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	971,505	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,916,535	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,846,388	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,758,581	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,050,514	0	0	0	38.00
39.00	Payroll taxes payable	32,364	0	0	0	39.00
40.00	Notes and loans payable (short term)	945,703	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	248,846	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,036,008	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,277,580	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,277,580	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	23,313,588	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	16,532,800				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	16,532,800	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,846,388	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet G-1 | Date/Time Prepared: 12/22/2016 8:49 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,647,471		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		915,348				2.00
3.00	Total (sum of line 1 and line 2)		16,562,819		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		16,562,819		0		11.00
12.00	DECREASE IN PERM RESTRICTED	30,019		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)		30,019		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,532,800		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/22/2016 8:49 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,882,681		1,882,681	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	974,820		974,820	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,857,501		2,857,501	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,857,501		2,857,501	17.00
18.00	Ancillary services	6,217,173	0	6,217,173	18.00
19.00	Outpatient services	0	35,826,901	35,826,901	19.00
20.00	RHC - CARLINVILLE	0	697,274	697,274	20.00
20.01	RHC - GIRARD	0	260,921	260,921	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,074,674	36,785,096	45,859,770	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,991,909		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)		22,991,909		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141347 | Period: From 08/01/2015 To 07/31/2016 | Worksheet G-3 | Date/Time Prepared: 12/22/2016 8:49 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	45,859,770	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,710,982	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,148,788	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,991,909	4.00
5.00	Net income from service to patients (line 3 minus line 4)	156,879	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	38,828	6.00
7.00	Income from investments	73,199	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	28,787	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	63,812	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	160,847	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	281,561	24.01
24.02	PHYSICAL THERAPY - NON PATIENTS	0	24.02
24.03	OTHER	66,154	24.03
24.04		0	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	16,622	24.05
24.06	GRANTS	28,659	24.06
25.00	Total other income (sum of lines 6-24)	758,469	25.00
26.00	Total (line 5 plus line 25)	915,348	26.00
27.00	LOSS FROM DISPOSAL	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	915,348	29.00

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

Provider CCN: 141347 Component CCN: 148530 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-1 | Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	369,805	0	369,805	-16,000	353,805	1.00
2.00	Physician Assistant	78,763	0	78,763	0	78,763	2.00
3.00	Nurse Practitioner	69,130	0	69,130	0	69,130	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	112,033	198,475	310,508	-46,855	263,653	9.00
10.00	Subtotal (sum of lines 1 through 9)	629,731	198,475	828,206	-62,855	765,351	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	629,731	198,475	828,206	-62,855	765,351	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	629,731	198,475	828,206	-62,855	765,351	32.00

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

Provider CCN: 141347 | Component CCN: 148530 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-1 | Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	353,805		1.00
2.00	Physician Assistant	0	78,763		2.00
3.00	Nurse Practitioner	0	69,130		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	263,653		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	765,351		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	765,351		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	765,351		32.00

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

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-1 | Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	16,000	16,000	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	104,522	0	104,522	0	104,522	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	92,151	46,619	138,770	-22,637	116,133	9.00
10.00	Subtotal (sum of lines 1 through 9)	196,673	46,619	243,292	-6,637	236,655	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	196,673	46,619	243,292	-6,637	236,655	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	196,673	46,619	243,292	-6,637	236,655	32.00

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

Provider CCN: 141347 | Component CCN: 148532 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-1 | Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	16,000		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	104,522		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	116,133		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	236,655		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	236,655		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	236,655		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 141347 | Component CCN: 148530 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-2 | Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.93	1,824	4,200	3,906		1.00
2.00	Physician Assistant	1.30	2,596	2,100	2,730		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.23	4,420		6,636	6,636	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.23	4,420			6,636	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	765,351	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	765,351	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	768,715	15.00
16.00	Total overhead (sum of lines 14 and 15)	768,715	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	768,715	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	768,715	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,534,066	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141347 Component CCN: 148532 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-2 Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.01	44	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.82	1,436	2,100	1,722		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.83	1,480		1,764	1,764	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.83	1,480			1,764	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					236,655	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					236,655	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					157,179	15.00
16.00	Total overhead (sum of lines 14 and 15)					157,179	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					157,179	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					157,179	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					393,834	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141347 | Component CCN: 148530 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-3 | Date/Time Prepared: 12/22/2016 8:49 am

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

		1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)	1,534,066	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	11,010	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,523,056	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	6,636	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	6,636	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	229.51	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)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	229.51	229.51	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,293	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	296,756	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		296,756	16.00
16.01	Total program charges (see instructions)(from contractor's records)		141,354	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,551	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		24,250	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.)		204,964	16.04
16.05	Total program cost (see instructions)		229,214	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,301	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,700	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		229,214	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,010	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		240,224	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		240,224	26.00
26.01	Sequestration adjustment (see instructions)		4,804	26.01
27.00	Interim payments		212,016	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)		23,404	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141347 | Component CCN: 148532 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-3 | Date/Time Prepared: 12/22/2016 8:49 am

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		393,834	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		635	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		393,199	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,764	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,764	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		222.90	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)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	222.90	222.90	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	355	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	79,130	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) *		79,130	16.00
16.01	Total program charges (see instructions)(from contractor's records)		47,524	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		701	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,167	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.)		58,014	16.04
16.05	Total program cost (see instructions)		59,181	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,445	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,275	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		59,181	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		635	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		59,816	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		59,816	26.00
26.01	Sequestration adjustment (see instructions)		1,196	26.01
27.00	Interim payments		55,704	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)		2,916	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141347 | Component CCN: 148530 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-4 | Date/Time Prepared: 12/22/2016 8:49 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	765,351	765,351	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000123	0.000150	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	94	115	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,614	670	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,708	785	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	765,351	765,351	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	768,715	768,715	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006151	0.001026	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,728	789	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,436	1,574	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	30	38	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	314.53	41.42	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	30	38	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,436	1,574	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		11,010	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		11,010	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141347 | Component CCN: 148532 | Period: From 08/01/2015 To 07/31/2016 | Worksheet M-4 | Date/Time Prepared: 12/22/2016 8:49 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	236,655	236,655	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000013	0.000130	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3	31	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	154	194	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	157	225	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	236,655	236,655	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	157,179	157,179	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000663	0.000951	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	104	149	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	261	374	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	11	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	261.00	34.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	11	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	261	374	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		635	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		635	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 08/01/2015 To 07/31/2016

Worksheet M-5

Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) I

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		179,630	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/08/2016	4,230	3.01
3.02		07/28/2016	28,156	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)		32,386	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		212,016	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		23,404	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		235,420	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 08/01/2015 To 07/31/2016

Worksheet M-5

Date/Time Prepared: 12/22/2016 8:49 am

Rural Health Clinic (RHC) II

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		48,711	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/08/2016	3,698	3.01
3.02		07/28/2016	3,295	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)		6,993	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		55,704	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		2,916	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		58,620	7.00

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