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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1347	Period: From 08/01/2016 To 07/31/2017	Worksheet S Parts I-III Date/Time Prepared: 12/18/2017 4:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 12/18/2017 Time: 4:02 pm
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 (14-1347) for the cost reporting period beginning 08/01/2016 and ending 07/31/2017 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	208,775	-20,712	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	99,696	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RHC - CARLINVILLE I	0		-15,197		0	10.00
10.01	RHC - GIRARD II	0		-21,924		0	10.01
200.00	Total	0	308,471	-57,833	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2017 1:10 pm

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CARLINVILLE AREA HOSPITAL	141347	99914	1	07/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CARLINVILLE AREA HOSPITAL SWING BED	14Z347	99914		07/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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)	08/01/2016	07/31/2017	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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2017 1:10 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2017 1:10 pm

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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:	188,366	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	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: 14-1347	Period: From 08/01/2016 To 07/31/2017	Worksheet S-2 Part I Date/Time Prepared: 12/18/2017 1:10 pm

		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)	10/01/2015	09/30/2016	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 12/18/2017 1:10 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/08/2017	Y	11/08/2017	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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 12/18/2017 1:10 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1347	Period: From 08/01/2016 To 07/31/2017	Worksheet S-2 Part II Date/Time Prepared: 12/18/2017 1:10 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 12/18/2017 1:10 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	35,208.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	35,208.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	35,208.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	88.00				0	26.00
26.01	RHC - GIRARD	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 12/18/2017 1:10 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,119	97	1,467			1.00
2.00	HMO and other (see instructions)	127	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	1,505	0	1,799			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	23			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,624	97	3,289			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,624	97	3,289	0.00	145.32	14.00
15.00	CAH visits	12,453	3,895	22,566			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	2,049	3,179	10,348	0.00	15.12	26.00
26.01	RHC - GIRARD	509	804	2,133	0.00	3.27	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	163.71	27.00
28.00	Observation Bed Days		55	364			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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 12/18/2017 1:10 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	377	46	523	1.00
2.00	HMO and other (see instructions)			42	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	377	46	523	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	0.00					26.00
26.01	RHC - GIRARD	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-8 | Date/Time Prepared: 12/18/2017 1:10 pm

RHC I | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street				1115 EAST MORGAN STREET, #2	1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CARLINVILLE		IL	62626	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	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	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MACOUPIN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:00	07:30	16:00	07:30	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 08/01/2016
To 07/31/2017

Worksheet S-8

Date/Time Prepared:
12/18/2017 1:10 pm

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 RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1347 | Component CCN: 14-8532 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-8 | Date/Time Prepared: 12/18/2017 1:10 pm

RHC II | Cost

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	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	RHC/FQHC name, CCN number			14.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 08/01/2016
To 07/31/2017

Worksheet S-8

Date/Time Prepared:
12/18/2017 1:10 pm

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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet S-10 | Date/Time Prepared: 12/18/2017 1:10 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.472870	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,711,093	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	1,983,522	5.00
6.00	Medicaid charges	9,036,975	6.00
7.00	Medicaid cost (line 1 times line 6)	4,273,314	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	26,140	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	352,241	0	352,241	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	166,564	0	166,564	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	166,564	0	166,564	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, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	968,165	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	253,398	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	389,843	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	578,322	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	409,916	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	576,480	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	576,480	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,658,533	1,658,533	785,309	2,443,842	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		599,450	599,450	15,694	615,144	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,199,393	2,199,393	0	2,199,393	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,296,158	2,469,528	3,765,686	138,414	3,904,100	5.00
7.00	00700	OPERATION OF PLANT	215,819	475,577	691,396	0	691,396	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,415	73,415	0	73,415	8.00
9.00	00900	HOUSEKEEPING	255,087	41,180	296,267	0	296,267	9.00
10.00	01000	DIETARY	173,591	220,930	394,521	0	394,521	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	312,901	17,202	330,103	0	330,103	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	149,113	76,004	225,117	0	225,117	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	167,897	6,230	174,127	0	174,127	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	902,733	362,424	1,265,157	0	1,265,157	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	261,381	623,265	884,646	0	884,646	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	443,872	834,974	1,278,846	1,713	1,280,559	54.00
60.00	06000	LABORATORY	633,480	671,520	1,305,000	0	1,305,000	60.00
65.00	06500	RESPIRATORY THERAPY	365,656	154,914	520,570	0	520,570	65.00
66.00	06600	PHYSICAL THERAPY	844,510	94,489	938,999	0	938,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	215,966	33,416	249,382	0	249,382	67.00
69.00	06900	ELECTROCARDIOLOGY	75,532	83,287	158,819	0	158,819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,378	166,296	250,674	0	250,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	51,044	51,044	0	51,044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,091	907,354	1,119,445	0	1,119,445	73.00
76.00	03550	BEHAVORIAL HEALTH	144,502	106,000	250,502	0	250,502	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	1,239,261	305,433	1,544,694	-175,903	1,368,791	88.00
88.01	08801	RHC - GIRARD	200,314	47,804	248,118	-35,792	212,326	88.01
90.00	09000	CLINIC	196,357	229,873	426,230	0	426,230	90.00
91.00	09100	EMERGENCY	1,144,095	1,679,491	2,823,586	0	2,823,586	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		729,435	729,435	-729,435	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,534,694	14,918,461	24,453,155	0	24,453,155	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	253,800	253,800	0	253,800	194.00
194.01	07951	FUND DEVELOPMENT	12,046	2,109	14,155	0	14,155	194.01
200.00		TOTAL (SUM OF LINES 118-199)	9,546,740	15,174,370	24,721,110	0	24,721,110	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-152,399	2,291,443		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-79,491	535,653		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,199,393		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-233,003	3,671,097		5.00
7.00	00700	OPERATION OF PLANT	-30	691,366		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,415		8.00
9.00	00900	HOUSEKEEPING	0	296,267		9.00
10.00	01000	DIETARY	-73,860	320,661		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	330,103		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,791	219,326		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	174,127		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,265,157		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-171,611	713,035		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-21,538	1,259,021		54.00
60.00	06000	LABORATORY	-300	1,304,700		60.00
65.00	06500	RESPIRATORY THERAPY	-10,564	510,006		65.00
66.00	06600	PHYSICAL THERAPY	-3,659	935,340		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	249,382		67.00
69.00	06900	ELECTROCARDIOLOGY	-45,159	113,660		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	250,674		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	51,044		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-37,135	1,082,310		73.00
76.00	03550	BEHAVORIAL HEALTH	0	250,502		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	1,368,791		88.00
88.01	08801	RHC - GIRARD	0	212,326		88.01
90.00	09000	CLINIC	-43,318	382,912		90.00
91.00	09100	EMERGENCY	-1,419,234	1,404,352		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)	-2,297,092	22,156,063		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	253,800		194.00
194.01	07951	FUND DEVELOPMENT	0	14,155		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,297,092	22,424,018		200.00

RECLASSIFICATIONS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-6 | Date/Time Prepared: 12/18/2017 1:10 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - RECLASS PHYSICIAN SALARY EXPENSE				
1.00	RHC - GIRARD	88.01	9,172	0	1.00
2.00	RHC - GIRARD	88.01	1,675	0	2.00
	TOTALS		10,847	0	
	C - INSURANCE EXPENSE				
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	73,281	1.00
	TOTALS		0	73,281	
	E - INTEREST EXPENSE RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,713	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	727,722	2.00
	TOTALS		0	729,435	
	L - RECLASS RHC ADMIN SALARIES TO ADMIN				
1.00	ADMINISTRATIVE & GENERAL	5.00	211,695	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		211,695	0	
500.00	Grand Total: Increases		222,542	802,716	500.00

RECLASSIFICATIONS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-6 | Date/Time Prepared: 12/18/2017 1:10 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - RECLASS PHYSICIAN SALARY EXPENSE						
1.00	RHC - CARLINVILLE	88.00	9,172	0	0		1.00
2.00	RHC - CARLINVILLE	88.00	1,675	0	0		2.00
	TOTALS		10,847	0			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,281	0		1.00
	TOTALS		0	73,281			
	E - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	729,435	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	729,435			
	L - RECLASS RHC ADMIN SALARIES TO ADMIN						
1.00	RHC - CARLINVILLE	88.00	165,056	0	0		1.00
2.00	RHC - GIRARD	88.01	46,639	0	0		2.00
	TOTALS		211,695	0			
500.00	Grand Total: Decreases		222,542	802,716			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 12/18/2017 1:10 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	517,171	0	0	0	0	1.00
2.00	Land Improvements	2,311,051	53,524	0	53,524	0	2.00
3.00	Buildings and Fixtures	25,551,127	310,533	0	310,533	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	6,321,708	331,197	0	331,197	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)	35,881,384	695,254	0	695,254	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,881,384	695,254	0	695,254	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	2,364,575	0	2.00
3.00	Buildings and Fixtures	25,861,660	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,652,905	0	6.00
7.00	HIT designated Assets	1,180,327	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,576,638	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	36,576,638	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 12/18/2017 1:10 pm

	Cost Center Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,658,533	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	599,450	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,257,983	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	1,658,533				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	599,450				2.00
3.00	Total (sum of lines 1-2)	0	2,257,983				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 12/18/2017 1:10 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	28,743,407	0	28,743,407	0.785841	57,587	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,833,231	0	7,833,231	0.214159	15,694	2.00
3.00	Total (sum of lines 1-2)	36,576,638	0	36,576,638	1.000000	73,281	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	57,587	2,233,856	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	15,694	519,959	0	2.00
3.00	Total (sum of lines 1-2)	0	0	73,281	2,753,815	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	57,587	0	0	2,291,443	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	15,694	0	0	535,653	2.00
3.00	Total (sum of lines 1-2)	0	73,281	0	0	2,827,096	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-8 | Date/Time Prepared: 12/18/2017 1:10 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-13,149	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,015	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	-2,312	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	-1,587,082			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-71,662	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	-37,135	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,791	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	-1,509	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	-3,195	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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-8 | Date/Time Prepared: 12/18/2017 1:10 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	DIETARY DISCOUNTS	B	-2,198	DIETARY	10.00	0	33.00
33.01	RADIOLOGY DISCOUNTS	B	-21,538	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	PT PROF FEES	B	-313	PHYSICAL THERAPY	66.00	0	33.02
33.03	PREVIOUS DEBT ISSUANCE COSTS	A	43,119	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.03
33.04	CONTRACT LAB	B	-300	LABORATORY	60.00	0	33.04
33.05	SUPPLIES	B	-3,763	OPERATING ROOM	50.00	0	33.05
33.06	AHA & IHA DUES	A	-8,552	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PLANT OPERATION DISCOUNTS	B	-30	OPERATION OF PLANT	7.00	0	33.07
36.00	ACQUATIC THERAPY	B	-3,346	PHYSICAL THERAPY	66.00	0	36.00
37.00			0		0.00	0	37.00
39.00	MED STAFF RELATIONS	A	-10,328	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00			0		0.00	0	40.00
41.00	NON-PATIENT REVENUE	B	-647	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING	A	-200,684	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	TELEPHONE DEPRECIATION	A	-2,576	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-4,006	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-43,318	CLINIC	90.00	0	44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,598	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	INSURANCE PROCEEDS	A	-2,861	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05	MOB BUILDING RENT	B	-176,598	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.05
44.06			0		0.00	0	44.06
44.07			0		0.00	0	44.07
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03			0		0.00	0	45.03
45.04			0		0.00	0	45.04
45.05	EKG PROFESSIONAL FEES	A	-45,159	ELECTROCARDIOLOGY	69.00	0	45.05
45.06	SLEEP STUDY PROFESSONAL FEES	A	-9,055	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.)		-2,297,092				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 12/18/2017 1:10 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,546,860	991,228	555,632	0	0	1.00
2.00	91.00	EMERGENCY	370,927	370,927	0	0	0	2.00
3.00	50.00	OPERATING ROOM	167,848	167,848	0	0	0	3.00
4.00	91.00	EMERGENCY	57,079	57,079	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			2,142,714	1,587,082	555,632		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	991,228		1.00
2.00	91.00	EMERGENCY	0	0	0	370,927		2.00
3.00	50.00	OPERATING ROOM	0	0	0	167,848		3.00
4.00	91.00	EMERGENCY	0	0	0	57,079		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	1,587,082		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/18/2017 1:10 pm

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	275.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.11	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)	40.56	40.56	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)					22,346	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)					22,346	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)					22,346	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)					81.11	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					63,266	22.00
23.00	Total salary equivalency (see instructions)					63,266	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/18/2017 1:10 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.11	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)	63,266		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)	63,266		63.00
64.00	Total cost of outside supplier services (from your records)	19,410		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: 14-1347	Period: From 08/01/2016 To 07/31/2017	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 12/18/2017 1:10 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.57	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	928.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	63.39	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)	31.70	31.70	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)	58,826	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)	58,826	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)	58,826	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	58,826	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 12/18/2017 1:10 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	63.39	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)		58,826	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)		58,826	63.00
64.00	Total cost of outside supplier services (from your records)		60,335	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		1,509	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	271.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.86	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)	38.43	38.43	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)	20,887	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)	20,887	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)	20,887	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)	76.86	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	59,951	22.00
23.00	Total salary equivalency (see instructions)	59,951	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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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)	76.86	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)	59,951	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	59,951	63.00
64.00	Total cost of outside supplier services (from your records)	17,664	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	539.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.86	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)	36.93	36.93	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)					39,829	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)					39,829	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)					39,829	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)					73.86	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					57,611	22.00
23.00	Total salary equivalency (see instructions)					57,611	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)	73.86	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)	57,611	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	57,611	63.00
64.00	Total cost of outside supplier services (from your records)	32,255	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B Part I Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,291,443	2,291,443				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	535,653		535,653			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,199,393	0	0	2,199,393		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,671,097	492,418	138,907	347,379	4,649,801	5.00
7.00	00700	OPERATION OF PLANT	691,366	264,030	24,259	49,721	1,029,376	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,415	0	0	0	73,415	8.00
9.00	00900	HOUSEKEEPING	296,267	10,791	19	58,767	365,844	9.00
10.00	01000	DIETARY	320,661	41,546	17,804	39,992	420,003	10.00
11.00	01100	CAFETERIA	0	41,864	0	0	41,864	11.00
13.00	01300	NURSING ADMINISTRATION	330,103	6,857	664	72,087	409,711	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219,326	30,928	4,963	34,353	289,570	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	174,127	2,286	1,900	38,680	216,993	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,265,157	324,266	40,475	207,973	1,837,871	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	713,035	152,180	56,875	60,217	982,307	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,259,021	102,187	100,165	102,260	1,563,633	54.00
60.00	06000	LABORATORY	1,304,700	42,616	13,966	145,942	1,507,224	60.00
65.00	06500	RESPIRATORY THERAPY	510,006	92,465	35,561	84,241	722,273	65.00
66.00	06600	PHYSICAL THERAPY	935,340	188,837	33,970	194,560	1,352,707	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,382	14,321	0	49,755	313,458	67.00
69.00	06900	ELECTROCARDIOLOGY	113,660	87,576	0	17,401	218,637	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,674	23,926	1,056	19,439	295,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,044	0	0	0	51,044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,082,310	18,632	5,199	48,862	1,155,003	73.00
76.00	03550	BEHAVORIAL HEALTH	250,502	38,132	999	33,291	322,924	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	1,368,791	170,783	29,531	244,979	1,814,084	88.00
88.01	08801	RHC - GIRARD	212,326	0	0	37,903	250,229	88.01
90.00	09000	CLINIC	382,912	73,862	2,975	45,237	504,986	90.00
91.00	09100	EMERGENCY	1,404,352	63,881	26,032	263,579	1,757,844	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)	22,156,063	2,284,384	535,320	2,196,618	22,145,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,294	20	0	5,314	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	253,800	0	0	0	253,800	194.00
194.01	07951	FUND DEVELOPMENT	14,155	1,765	313	2,775	19,008	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)	22,424,018	2,291,443	535,653	2,199,393	22,424,018	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B Part I | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,649,801					5.00
7.00	00700	OPERATION OF PLANT	269,289	1,298,665				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,206	0	92,621			8.00
9.00	00900	HOUSEKEEPING	95,706	9,130	0	470,680		9.00
10.00	01000	DIETARY	109,874	35,149	0	12,196	577,222	10.00
11.00	01100	CAFETERIA	10,952	35,419	0	12,289	326,535	11.00
13.00	01300	NURSING ADMINISTRATION	107,182	5,801	0	2,013	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,753	26,166	0	9,079	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56,766	1,934	0	671	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	480,789	274,342	43,573	95,186	250,687	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	256,975	128,750	7,700	44,672	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	409,053	86,454	8,508	29,997	0	54.00
60.00	06000	LABORATORY	394,296	36,055	0	12,510	0	60.00
65.00	06500	RESPIRATORY THERAPY	188,950	78,229	648	27,143	0	65.00
66.00	06600	PHYSICAL THERAPY	353,874	159,763	7,586	55,433	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	82,002	12,116	0	4,204	0	67.00
69.00	06900	ELECTROCARDIOLOGY	57,196	74,093	0	25,708	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,198	20,243	0	7,024	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,353	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	302,153	15,763	0	5,469	0	73.00
76.00	03550	BEHAVORIAL HEALTH	84,478	32,261	0	11,194	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	474,572	144,489	52	50,133	0	88.00
88.01	08801	RHC - GIRARD	65,461	0	0	23,253	0	88.01
90.00	09000	CLINIC	132,106	62,490	0	21,682	0	90.00
91.00	09100	EMERGENCY	459,859	54,046	24,554	18,752	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)	4,577,043	1,292,693	92,621	468,608	577,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,390	4,479	0	1,554	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	66,395	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	4,973	1,493	0	518	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)	4,649,801	1,298,665	92,621	470,680	577,222	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B Part I | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	427,059					11.00
13.00	01300	NURSING ADMINISTRATION	12,876	537,583				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,704	0	416,272			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,462	8,882	5,479	294,187		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,820	235,544	25,316	0	3,335,128	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,604	45,161	20,372	0	1,503,541	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	294,187	294,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,857	0	108,187	0	2,239,689	54.00
60.00	06000	LABORATORY	47,704	0	82,616	0	2,080,405	60.00
65.00	06500	RESPIRATORY THERAPY	30,902	0	11,089	0	1,059,234	65.00
66.00	06600	PHYSICAL THERAPY	50,491	0	39,230	0	2,019,084	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,032	0	8,622	0	432,434	67.00
69.00	06900	ELECTROCARDIOLOGY	5,615	0	8,291	0	389,540	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,430	0	9,968	0	416,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	804	0	65,201	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,934	28,047	28,297	0	1,545,666	73.00
76.00	03550	BEHAVORIAL HEALTH	12,623	32,379	2,579	0	498,438	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	14,190	0	2,497,520	88.00
88.01	08801	RHC - GIRARD	0	0	2,465	0	341,408	88.01
90.00	09000	CLINIC	16,295	41,803	4,864	0	784,226	90.00
91.00	09100	EMERGENCY	56,823	145,767	43,903	0	2,561,548	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)	426,172	537,583	416,272	294,187	22,064,207	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	12,737	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	320,195	194.00
194.01	07951	FUND DEVELOPMENT	887	0	0	0	26,879	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)	427,059	537,583	416,272	294,187	22,424,018	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B Part I | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,335,128		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,503,541		50.00
53.00	05300	ANESTHESIOLOGY	0	294,187		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,239,689		54.00
60.00	06000	LABORATORY	0	2,080,405		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,059,234		65.00
66.00	06600	PHYSICAL THERAPY	0	2,019,084		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	432,434		67.00
69.00	06900	ELECTROCARDIOLOGY	0	389,540		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	416,958		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,201		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,545,666		73.00
76.00	03550	BEHAVORIAL HEALTH	0	498,438		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	2,497,520		88.00
88.01	08801	RHC - GIRARD	0	341,408		88.01
90.00	09000	CLINIC	0	784,226		90.00
91.00	09100	EMERGENCY	0	2,561,548		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	22,064,207		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,737		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	320,195		194.00
194.01	07951	FUND DEVELOPMENT	0	26,879		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	22,424,018		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B Part II Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,321	492,418	138,907	670,646	0	5.00
7.00	00700	OPERATION OF PLANT	144	264,030	24,259	288,433	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	10,791	19	10,810	0	9.00
10.00	01000	DIETARY	1,600	41,546	17,804	60,950	0	10.00
11.00	01100	CAFETERIA	0	41,864	0	41,864	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,857	664	7,521	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,928	4,963	35,891	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,286	1,900	4,186	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,442	324,266	40,475	369,183	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	282,883	152,180	56,875	491,938	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,638	102,187	100,165	270,990	0	54.00
60.00	06000	LABORATORY	33,935	42,616	13,966	90,517	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,629	92,465	35,561	145,655	0	65.00
66.00	06600	PHYSICAL THERAPY	0	188,837	33,970	222,807	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,321	0	14,321	0	67.00
69.00	06900	ELECTROCARDIOLOGY	7,440	87,576	0	95,016	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,926	1,056	24,982	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	76,960	18,632	5,199	100,791	0	73.00
76.00	03550	BEHAVORIAL HEALTH	0	38,132	999	39,131	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	170,783	29,531	200,314	0	88.00
88.01	08801	RHC - GIRARD	24,642	0	0	24,642	0	88.01
90.00	09000	CLINIC	0	73,862	2,975	76,837	0	90.00
91.00	09100	EMERGENCY	0	63,881	26,032	89,913	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)	557,634	2,284,384	535,320	3,377,338	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,294	20	5,314	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	1,765	313	2,078	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)	557,634	2,291,443	535,653	3,384,730	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B Part II | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	670,646					5.00
7.00	00700	OPERATION OF PLANT	38,839	327,272				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,770	0	2,770			8.00
9.00	00900	HOUSEKEEPING	13,804	2,301	0	26,915		9.00
10.00	01000	DIETARY	15,847	8,858	0	697	86,352	10.00
11.00	01100	CAFETERIA	1,580	8,926	0	703	48,849	11.00
13.00	01300	NURSING ADMINISTRATION	15,459	1,462	0	115	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,926	6,594	0	519	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,187	487	0	38	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,354	69,137	1,304	5,444	37,503	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,063	32,446	230	2,554	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,997	21,787	254	1,715	0	54.00
60.00	06000	LABORATORY	56,869	9,086	0	715	0	60.00
65.00	06500	RESPIRATORY THERAPY	27,252	19,714	19	1,552	0	65.00
66.00	06600	PHYSICAL THERAPY	51,039	40,261	227	3,170	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,827	3,053	0	240	0	67.00
69.00	06900	ELECTROCARDIOLOGY	8,249	18,672	0	1,470	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,134	5,101	0	402	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,926	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,579	3,972	0	313	0	73.00
76.00	03550	BEHAVORIAL HEALTH	12,184	8,130	0	640	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	68,447	36,412	2	2,867	0	88.00
88.01	08801	RHC - GIRARD	9,441	0	0	1,330	0	88.01
90.00	09000	CLINIC	19,054	15,748	0	1,240	0	90.00
91.00	09100	EMERGENCY	66,325	13,620	734	1,072	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)	660,152	325,767	2,770	26,796	86,352	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	201	1,129	0	89	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	9,576	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	717	376	0	30	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	670,646	327,272	2,770	26,915	86,352	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B Part II | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	101,922					11.00
13.00	01300	NURSING ADMINISTRATION	3,073	27,630				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,748	0	57,678			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	826	457	759	14,940		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,915	12,105	3,508		589,453	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,201	2,321	2,823		573,576	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,080	0	14,993		376,816	54.00
60.00	06000	LABORATORY	11,385	0	11,446		180,018	60.00
65.00	06500	RESPIRATORY THERAPY	7,375	0	1,536		203,103	65.00
66.00	06600	PHYSICAL THERAPY	12,050	0	5,435		334,989	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,871	0	1,195		33,507	67.00
69.00	06900	ELECTROCARDIOLOGY	1,340	0	1,149		125,896	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,773	0	1,381		44,773	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	111		2,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,610	1,442	3,920		156,627	73.00
76.00	03550	BEHAVORIAL HEALTH	3,013	1,664	357		65,119	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	1,966		310,008	88.00
88.01	08801	RHC - GIRARD	0	0	342		35,755	88.01
90.00	09000	CLINIC	3,889	2,149	674		119,591	90.00
91.00	09100	EMERGENCY	13,561	7,492	6,083		198,800	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)	101,710	27,630	57,678	0	3,350,068	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		6,733	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		9,576	194.00
194.01	07951	FUND DEVELOPMENT	212	0	0		3,413	194.01
200.00		Cross Foot Adjustments				14,940	14,940	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	101,922	27,630	57,678	14,940	3,384,730	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B Part II | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	589,453		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	573,576		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	376,816		54.00
60.00	06000	LABORATORY	0	180,018		60.00
65.00	06500	RESPIRATORY THERAPY	0	203,103		65.00
66.00	06600	PHYSICAL THERAPY	0	334,989		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,507		67.00
69.00	06900	ELECTROCARDIOLOGY	0	125,896		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,773		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,037		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	156,627		73.00
76.00	03550	BEHAVORIAL HEALTH	0	65,119		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	0	310,008		88.00
88.01	08801	RHC - GIRARD	0	35,755		88.01
90.00	09000	CLINIC	0	119,591		90.00
91.00	09100	EMERGENCY	0	198,800		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	3,350,068		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	6,733		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	9,576		194.00
194.01	07951	FUND DEVELOPMENT	0	3,413		194.01
200.00		Cross Foot Adjustments	0	14,940		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	3,384,730		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B-1 | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	79,202					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		480,439				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,546,740			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,020	124,591	1,507,853	-4,649,801	17,774,217	5.00
7.00	00700	OPERATION OF PLANT	9,126	21,758	215,819	0	1,029,376	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	73,415	8.00
9.00	00900	HOUSEKEEPING	373	17	255,087	0	365,844	9.00
10.00	01000	DIETARY	1,436	15,969	173,591	0	420,003	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	41,864	11.00
13.00	01300	NURSING ADMINISTRATION	237	596	312,901	0	409,711	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	4,451	149,113	0	289,570	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	1,704	167,897	0	216,993	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	36,303	902,733	0	1,837,871	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	51,012	261,381	0	982,307	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	89,840	443,872	0	1,563,633	54.00
60.00	06000	LABORATORY	1,473	12,526	633,480	0	1,507,224	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	31,895	365,656	0	722,273	65.00
66.00	06600	PHYSICAL THERAPY	6,527	30,468	844,510	0	1,352,707	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	215,966	0	313,458	67.00
69.00	06900	ELECTROCARDIOLOGY	3,027	0	75,532	0	218,637	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	947	84,378	0	295,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	51,044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	4,663	212,091	0	1,155,003	73.00
76.00	03550	BEHAVORIAL HEALTH	1,318	896	144,502	0	322,924	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	5,903	26,487	1,063,358	0	1,814,084	88.00
88.01	08801	RHC - GIRARD	0	0	164,522	0	250,229	88.01
90.00	09000	CLINIC	2,553	2,668	196,357	0	504,986	90.00
91.00	09100	EMERGENCY	2,208	23,349	1,144,095	0	1,757,844	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)	78,958	480,140	9,534,694	-4,649,801	17,496,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	5,314	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	253,800	194.00
194.01	07951	FUND DEVELOPMENT	61	281	12,046	0	19,008	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)	2,291,443	535,653	2,199,393		4,649,801	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.931631	1.114924	0.230382		0.261604	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		670,646	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.037731	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	53,056					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	118,293				8.00
9.00	00900	HOUSEKEEPING	373	0	55,421			9.00
10.00	01000	DIETARY	1,436	0	1,436	33,417		10.00
11.00	01100	CAFETERIA	1,447	0	1,447	18,904	10,116	11.00
13.00	01300	NURSING ADMINISTRATION	237	0	237	0	305	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,069	0	1,069	0	372	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	82	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	55,650	11,208	14,513	2,175	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	9,834	5,260	0	417	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	10,866	3,532	0	802	54.00
60.00	06000	LABORATORY	1,473	0	1,473	0	1,130	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	827	3,196	0	732	65.00
66.00	06600	PHYSICAL THERAPY	6,527	9,689	6,527	0	1,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	495	0	285	67.00
69.00	06900	ELECTROCARDIOLOGY	3,027	0	3,027	0	133	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	0	827	0	176	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	259	73.00
76.00	03550	BEHAVORIAL HEALTH	1,318	0	1,318	0	299	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	5,903	67	5,903	0	0	88.00
88.01	08801	RHC - GIRARD	0	0	2,738	0	0	88.01
90.00	09000	CLINIC	2,553	0	2,553	0	386	90.00
91.00	09100	EMERGENCY	2,208	31,360	2,208	0	1,346	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)	52,812	118,293	55,177	33,417	10,095	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	21	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)	1,298,665	92,621	470,680	577,222	427,059	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.477250	0.782980	8.492810	17.273304	42.216192	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	327,272	2,770	26,915	86,352	101,922	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.168426	0.023416	0.485646	2.584074	10.075326	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet B-1 | Date/Time Prepared: 12/18/2017 1:10 pm

		Cost Center Description	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	103,252				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,660,158			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,706	614,141	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	45,240	2,837,827	0		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,674	2,283,632	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,125,344	0		54.00
60.00	06000	LABORATORY	0	9,260,794	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,243,004	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,397,494	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	966,501	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	929,328	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,117,318	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,160	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,387	3,171,906	0		73.00
76.00	03550	BEHAVORIAL HEALTH	6,219	289,149	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	0	1,590,634	0		88.00
88.01	08801	RHC - GIRARD	0	276,352	0		88.01
90.00	09000	CLINIC	8,029	545,243	0		90.00
91.00	09100	EMERGENCY	27,997	4,921,331	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)	103,252	46,660,158	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)	537,583	416,272	294,187		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.206514	0.008921	2,941.870000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,630	57,678	14,940		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.267598	0.001236	149.400000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet C Part I Date/Time Prepared: 12/18/2017 1:10 pm

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	3,335,128		3,335,128	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,503,541		1,503,541	0	0	50.00
53.00	05300	ANESTHESIOLOGY	294,187		294,187	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,239,689		2,239,689	0	0	54.00
60.00	06000	LABORATORY	2,080,405		2,080,405	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,059,234	0	1,059,234	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,019,084	0	2,019,084	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	432,434	0	432,434	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	389,540		389,540	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	416,958		416,958	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,201		65,201	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,545,666		1,545,666	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	498,438		498,438	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	2,497,520		2,497,520	0	0	88.00
88.01	08801	RHC - GIRARD	341,408		341,408	0	0	88.01
90.00	09000	CLINIC	784,226		784,226	0	0	90.00
91.00	09100	EMERGENCY	2,561,548		2,561,548	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	334,094		334,094		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)	22,398,301	0	22,398,301	0	0	200.00
201.00		Less Observation Beds	334,094		334,094		0	201.00
202.00		Total (see instructions)	22,064,207	0	22,064,207	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet C Part I Date/Time Prepared: 12/18/2017 1:10 pm

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	2,158,616		2,158,616			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,725	2,261,907	2,283,632	0.658399	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	6,960	607,181	614,141	0.479022	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	797,555	11,327,789	12,125,344	0.184711	0.000000	54.00
60.00	06000	LABORATORY	1,135,797	8,156,473	9,292,270	0.223886	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	546,875	696,129	1,243,004	0.852157	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	723,756	3,673,738	4,397,494	0.459144	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	577,423	389,078	966,501	0.447422	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	39,748	889,580	929,328	0.419163	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	569,824	547,494	1,117,318	0.373178	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,160	90,160	0.723170	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,500,543	1,671,363	3,171,906	0.487299	0.000000	73.00
76.00	03550	BEHAVORIAL HEALTH	0	289,149	289,149	1.723810	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	1,590,634	1,590,634			88.00
88.01	08801	RHC - GIRARD	0	276,352	276,352			88.01
90.00	09000	CLINIC	7,000	538,243	545,243	1.438305	0.000000	90.00
91.00	09100	EMERGENCY	133,803	4,756,052	4,889,855	0.523849	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	34,763	644,448	679,211	0.491885	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)	8,254,388	38,405,770	46,660,158			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,254,388	38,405,770	46,660,158			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet C Part I Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D Part II Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	573,576	2,283,632	0.251168	7,181	1,804	50.00
53.00	05300	ANESTHESIOLOGY	0	614,141	0.000000	2,188	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	376,816	12,125,344	0.031077	505,186	15,700	54.00
60.00	06000	LABORATORY	180,018	9,292,270	0.019373	543,621	10,532	60.00
65.00	06500	RESPIRATORY THERAPY	203,103	1,243,004	0.163397	309,284	50,536	65.00
66.00	06600	PHYSICAL THERAPY	334,989	4,397,494	0.076177	119,606	9,111	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,507	966,501	0.034668	72,525	2,514	67.00
69.00	06900	ELECTROCARDIOLOGY	125,896	929,328	0.135470	25,673	3,478	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,773	1,117,318	0.040072	296,780	11,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,037	90,160	0.022593	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	156,627	3,171,906	0.049379	669,478	33,058	73.00
76.00	03550	BEHAVORIAL HEALTH	65,119	289,149	0.225209	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	310,008	1,590,634	0.194896	0	0	88.00
88.01	08801	RHC - GIRARD	35,755	276,352	0.129382	0	0	88.01
90.00	09000	CLINIC	119,591	545,243	0.219335	1,886	414	90.00
91.00	09100	EMERGENCY	198,800	4,889,855	0.040656	14,640	595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	59,048	679,211	0.086936	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,819,663	44,501,542		2,568,048	139,635	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D Part IV | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	294,187	0	0	0	294,187	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)	294,187	0	0	0	294,187	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D Part IV | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,283,632	0.000000	0.000000	7,181	50.00
53.00	05300	ANESTHESIOLOGY	0	614,141	0.479022	0.000000	2,188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,125,344	0.000000	0.000000	505,186	54.00
60.00	06000	LABORATORY	0	9,292,270	0.000000	0.000000	543,621	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,243,004	0.000000	0.000000	309,284	65.00
66.00	06600	PHYSICAL THERAPY	0	4,397,494	0.000000	0.000000	119,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	966,501	0.000000	0.000000	72,525	67.00
69.00	06900	ELECTROCARDIOLOGY	0	929,328	0.000000	0.000000	25,673	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,117,318	0.000000	0.000000	296,780	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,160	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,171,906	0.000000	0.000000	669,478	73.00
76.00	03550	BEHAVORIAL HEALTH	0	289,149	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	1,590,634	0.000000	0.000000	0	88.00
88.01	08801	RHC - GIRARD	0	276,352	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	545,243	0.000000	0.000000	1,886	90.00
91.00	09100	EMERGENCY	0	4,889,855	0.000000	0.000000	14,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	679,211	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	44,501,542			2,568,048	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D Part IV | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	1,048	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)	1,048	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D Part V Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.658399	0	1,117,657	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.479022	0	311,629	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184711	0	4,506,225	0	0	54.00
60.00	06000	LABORATORY	0.223886	0	3,710,070	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.852157	0	333,647	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.459144	0	1,405,145	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.447422	0	103,273	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.419163	0	454,342	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.373178	0	235,038	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.723170	0	67,010	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.487299	0	1,020,961	3,809	0	73.00
76.00	03550	BEHAVORIAL HEALTH	1.723810	0	289,149	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	1.438305	0	397,321	0	0	90.00
91.00	09100	EMERGENCY	0.523849	0	1,711,008	141	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.491885	0	387,115	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	16,049,590	3,950	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	16,049,590	3,950	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D Part V Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	735,864	0		50.00
53.00	05300	ANESTHESIOLOGY	149,277	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832,349	0		54.00
60.00	06000	LABORATORY	830,633	0		60.00
65.00	06500	RESPIRATORY THERAPY	284,320	0		65.00
66.00	06600	PHYSICAL THERAPY	645,164	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	46,207	0		67.00
69.00	06900	ELECTROCARDIOLOGY	190,443	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,711	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,460	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	497,513	1,856		73.00
76.00	03550	BEHAVORIAL HEALTH	498,438	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	571,469	0		90.00
91.00	09100	EMERGENCY	896,310	74		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	190,416	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,504,574	1,930		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,504,574	1,930		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D Part V Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.658399	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.479022	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184711	0	0	0	0	54.00
60.00	06000	LABORATORY	0.223886	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.852157	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.459144	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.447422	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.419163	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.373178	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.723170	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.487299	0	0	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	1.723810	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	1.438305	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.523849	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.491885	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D Part V | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D-1 | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,653	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,831	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)	1,467	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	660	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	1,139	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	23	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,119	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	554	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	951	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	147.50	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,335,128	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	3,392	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)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,654,568	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,680,560	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)	1,680,560	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)	917.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,027,052	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,027,052	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D-1 | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,029,853	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,056,905	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)	508,478	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	872,856	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,381,334	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)	364	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	917.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	334,094	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D-1 | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	589,453	3,335,128	0.176741	334,094	59,048	90.00
91.00	Nursing School cost	0	3,335,128	0.000000	334,094	0	91.00
92.00	Allied health cost	0	3,335,128	0.000000	334,094	0	92.00
93.00	All other Medical Education	0	3,335,128	0.000000	334,094	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D-3 | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,006,860		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.658399	7,181	4,728	50.00
53.00	05300	ANESTHESIOLOGY	0.479022	2,188	1,048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184711	505,186	93,313	54.00
60.00	06000	LABORATORY	0.223886	543,621	121,709	60.00
65.00	06500	RESPIRATORY THERAPY	0.852157	309,284	263,559	65.00
66.00	06600	PHYSICAL THERAPY	0.459144	119,606	54,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.447422	72,525	32,449	67.00
69.00	06900	ELECTROCARDIOLOGY	0.419163	25,673	10,761	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.373178	296,780	110,752	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.723170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.487299	669,478	326,236	73.00
76.00	03550	BEHAVORIAL HEALTH	1.723810	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	1.438305	1,886	2,713	90.00
91.00	09100	EMERGENCY	0.523849	14,640	7,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.491885	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,568,048	1,029,853	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)		2,568,048		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet D-3 | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.658399	4,368	2,876	50.00
53.00	05300	ANESTHESIOLOGY	0.479022	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.184711	148,387	27,409	54.00
60.00	06000	LABORATORY	0.223886	336,681	75,378	60.00
65.00	06500	RESPIRATORY THERAPY	0.852157	165,960	141,424	65.00
66.00	06600	PHYSICAL THERAPY	0.459144	476,160	218,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.447422	398,183	178,156	67.00
69.00	06900	ELECTROCARDIOLOGY	0.419163	6,868	2,879	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.373178	196,313	73,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.723170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.487299	552,074	269,025	73.00
76.00	03550	BEHAVORIAL HEALTH	1.723810	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	1.438305	5,100	7,335	90.00
91.00	09100	EMERGENCY	0.523849	13,908	7,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.491885	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,304,002	1,003,654	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)		2,304,002		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1347	Period: From 08/01/2016 To 07/31/2017	Worksheet E Part B Date/Time Prepared: 12/18/2017 1:10 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,506,504	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)	6,506,504	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)	6,571,569	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)	48,681	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,469,132	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)	4,053,756	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)	4,053,756	30.00
31.00	Primary payer payments	20	31.00
32.00	Subtotal (line 30 minus line 31)	4,053,736	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)	311,471	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	202,456	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	308,887	36.00
37.00	Subtotal (see instructions)	4,256,192	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)	4,256,192	40.00
40.01	Sequestration adjustment (see instructions)	85,124	40.01
41.00	Interim payments	4,191,780	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-20,712	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,457,105		3,888,796	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	03/02/2017	17,850	03/02/2017	81,561	3.01
3.02		07/31/2017	38,135	07/31/2017	221,423	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		55,985		302,984	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)		1,513,090		4,191,780	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		208,775		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		20,712	6.02
7.00	Total Medicare program liability (see instructions)		1,721,865		4,171,068	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,178,076		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	03/02/2017	37,394		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		37,394		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)		2,215,470		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		99,696		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,315,166		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1347	Period: From 08/01/2016 To 07/31/2017	Worksheet E-1 Part II Date/Time Prepared: 12/18/2017 1:10 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	523	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,119	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	127	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,467	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	46,660,158	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	352,241	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	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: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet E-2 | Date/Time Prepared: 12/18/2017 1:10 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,395,147	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)	1,013,691	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	1,505	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,408,838	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,408,838	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,408,838	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	46,424	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)	2,362,414	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)	2,362,414	0	19.00
19.01	Sequestration adjustment (see instructions)	47,248	0	19.01
20.00	Interim payments	2,215,470	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)	99,696	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: 14-1347	Period: From 08/01/2016 To 07/31/2017	Worksheet E-3 Part V Date/Time Prepared: 12/18/2017 1:10 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,056,905	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)	2,056,905	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,077,474	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)	2,077,474	19.00
20.00	Deductibles (exclude professional component)	370,445	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,707,029	22.00
23.00	Coinsurance	966	23.00
24.00	Subtotal (line 22 minus line 23)	1,706,063	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	78,372	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	50,942	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	77,084	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,757,005	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)	1,757,005	30.00
30.01	Sequestration adjustment (see instructions)	35,140	30.01
31.00	Interim payments	1,513,090	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)	208,775	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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet G | Date/Time Prepared: 12/18/2017 1:10 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,439,352	0	0	0	1.00
2.00	Temporary investments	120,208	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,963,897	0	0	0	4.00
5.00	Other receivable	140,495	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-679,000	0	0	0	6.00
7.00	Inventory	220,431	0	0	0	7.00
8.00	Prepaid expenses	222,169	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,427,552	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	517,172	0	0	0	12.00
13.00	Land improvements	2,364,575	0	0	0	13.00
14.00	Accumulated depreciation	-645,666	0	0	0	14.00
15.00	Buildings	25,861,660	0	0	0	15.00
16.00	Accumulated depreciation	-8,618,969	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	6,652,905	0	0	0	23.00
24.00	Accumulated depreciation	-4,748,061	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	-932,768	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)	21,631,175	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	5,326,031	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,326,031	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,384,758	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	511,826	0	0	0	37.00
38.00	Salaries, wages, and fees payable	893,665	0	0	0	38.00
39.00	Payroll taxes payable	32,786	0	0	0	39.00
40.00	Notes and loans payable (short term)	908,847	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	149,717	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,496,841	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,443,546	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)	16,443,546	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,940,387	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	16,444,371				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)	16,444,371	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,384,758	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet G-1 | Date/Time Prepared: 12/18/2017 1:10 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,532,800		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-87,653				2.00
3.00	Total (sum of line 1 and line 2)		16,445,147		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)		16,445,147		0		11.00
12.00	DECREASE IN PERM RESTRICTED	776		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)		776		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,444,371		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: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/18/2017 1:10 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,036,448		2,036,448	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	829,445		829,445	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)	2,865,893		2,865,893	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)	2,865,893		2,865,893	17.00
18.00	Ancillary services	5,916,781	0	5,916,781	18.00
19.00	Outpatient services	0	38,957,132	38,957,132	19.00
20.00	RHC - CARLINVILLE	0	1,590,634	1,590,634	20.00
20.01	RHC - GIRARD	0	334,175	334,175	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,782,674	40,881,941	49,664,615	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,721,110		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	MISC	291			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)		291		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,720,819		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2016 To 07/31/2017 | Worksheet G-3 | Date/Time Prepared: 12/18/2017 1:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,664,615	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,665,354	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,999,261	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,720,819	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-721,558	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	58,709	6.00
7.00	Income from investments	85,356	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	25,889	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	71,662	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	219,916	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	62,642	24.01
24.02	PHYSICAL THERAPY - NON PATIENTS	0	24.02
24.03	OTHER	69,391	24.03
24.04		0	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	14,200	24.05
24.06	GRANTS	26,140	24.06
25.00	Total other income (sum of lines 6-24)	633,905	25.00
26.00	Total (line 5 plus line 25)	-87,653	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)	-87,653	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2016 To 07/31/2017 | Worksheet M-1 | Date/Time Prepared: 12/18/2017 1:10 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	597,417	0	597,417	-9,172	588,245	1.00
2.00	Physician Assistant	87,104	0	87,104	-1,675	85,429	2.00
3.00	Nurse Practitioner	73,282	0	73,282	0	73,282	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	481,458	305,433	786,891	-165,056	621,835	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,239,261	305,433	1,544,694	-175,903	1,368,791	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,239,261	305,433	1,544,694	-175,903	1,368,791	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,239,261	305,433	1,544,694	-175,903	1,368,791	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2016 To 07/31/2017 | Worksheet M-1 | Date/Time Prepared: 12/18/2017 1:10 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	588,245		1.00
2.00	Physician Assistant	0	85,429		2.00
3.00	Nurse Practitioner	0	73,282		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	621,835		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,368,791		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,368,791		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,368,791		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347 | Component CCN: 14-8532 | Period: From 08/01/2016 To 07/31/2017 | Worksheet M-1 | Date/Time Prepared: 12/18/2017 1:10 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	9,172	9,172	1.00
2.00	Physician Assistant	0	0	0	1,675	1,675	2.00
3.00	Nurse Practitioner	110,772	0	110,772	0	110,772	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	89,542	47,804	137,346	-46,639	90,707	9.00
10.00	Subtotal (sum of lines 1 through 9)	200,314	47,804	248,118	-35,792	212,326	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						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)	200,314	47,804	248,118	-35,792	212,326	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						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)	200,314	47,804	248,118	-35,792	212,326	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347 | Component CCN: 14-8532 | Period: From 08/01/2016 To 07/31/2017 | Worksheet M-1 | Date/Time Prepared: 12/18/2017 1:10 pm

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	9,172		1.00
2.00	Physician Assistant	0	1,675		2.00
3.00	Nurse Practitioner	0	110,772		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	90,707		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	212,326		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				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	212,326		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				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	212,326		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2016 To 07/31/2017 | Worksheet M-2 | Date/Time Prepared: 12/18/2017 1:10 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.18	7,892	4,200	9,156		1.00
2.00	Physician Assistant	0.67	925	2,100	1,407		2.00
3.00	Nurse Practitioner	0.69	1,531	2,100	1,449		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.54	10,348		12,012	12,012	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)	3.54	10,348			12,012	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,368,791	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,368,791	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,128,729	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,128,729	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,128,729	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,128,729	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,497,520	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347 | Component CCN: 14-8532 | Period: From 08/01/2016 To 07/31/2017 | Worksheet M-2 | Date/Time Prepared: 12/18/2017 1:10 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.04	146	4,200	168		1.00
2.00	Physician Assistant	0.01	60	2,100	21		2.00
3.00	Nurse Practitioner	0.87	1,927	2,100	1,827		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.92	2,133		2,016	2,133	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)	0.92	2,133			2,133	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					212,326	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)					212,326	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					129,082	15.00
16.00	Total overhead (sum of lines 14 and 15)					129,082	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					129,082	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					129,082	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					341,408	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2016 To 07/31/2017	Worksheet M-3 Date/Time Prepared: 12/18/2017 1:10 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,497,520	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			11,261	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,486,259	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,012	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			12,012	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			206.98	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30		8.00
9.00	Rate for Program covered visits (see instructions)	206.98	206.98		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,049		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	424,102		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	424,102		16.00
16.01	Total program charges (see instructions)(from contractor's records)		246,224		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,254		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		38,331		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.)		282,662		16.04
16.05	Total program cost (see instructions)	0	320,993		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		32,444		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		38,305		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		320,993		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,261		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		332,254		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)		332,254		26.00
26.01	Sequestration adjustment (see instructions)		6,645		26.01
27.00	Interim payments		340,806		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)		-15,197		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1347 Component CCN: 14-8532	Period: From 08/01/2016 To 07/31/2017	Worksheet M-3 Date/Time Prepared: 12/18/2017 1:10 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		341,408	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		1,020	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		340,388	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,133	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,133	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		159.58	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	159.58	159.58	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	509	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	81,226	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	81,226	16.00
16.01	Total program charges (see instructions)(from contractor's records)		62,707	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,828	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,959	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.)		53,842	16.04
16.05	Total program cost (see instructions)	0	58,801	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,964	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,983	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		58,801	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,020	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		59,821	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)		59,821	26.00
26.01	Sequestration adjustment (see instructions)		1,196	26.01
27.00	Interim payments		80,549	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)		-21,924	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2016 To 07/31/2017	Worksheet M-4 Date/Time Prepared: 12/18/2017 1:10 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,368,791	1,368,791	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000094	0.000128	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	129	175	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,075	793	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,204	968	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,368,791	1,368,791	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,128,729	1,128,729	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003802	0.000707	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,291	798	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,495	1,766	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	33	45	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	287.73	39.24	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	33	45	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,495	1,766	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)		11,261	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)		11,261	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1347 Component CCN: 14-8532	Period: From 08/01/2016 To 07/31/2017	Worksheet M-4 Date/Time Prepared: 12/18/2017 1:10 pm
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	212,326	212,326	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000035	0.000259	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	7	55	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	308	264	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	315	319	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	212,326	212,326	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	129,082	129,082	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001484	0.001502	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	192	194	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	507	513	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	2	15	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	253.50	34.20	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	15	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	507	513	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		1,020	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)		1,020	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2016 To 07/31/2017	Worksheet M-5 Date/Time Prepared: 12/18/2017 1:10 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		340,806	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		340,806	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,197	6.02
7.00	Total Medicare program liability (see instructions)		325,609	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1347 Component CCN: 14-8532	Period: From 08/01/2016 To 07/31/2017	Worksheet M-5 Date/Time Prepared: 12/18/2017 1:10 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		80,549	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		80,549	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		21,924	6.02
7.00	Total Medicare program liability (see instructions)		58,625	7.00

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