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 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1347	Period: From 08/01/2022 To 07/31/2023	Worksheet S Parts I-III Date/Time Prepared: 12/18/2023 8:08 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: — Time:
2. [ ] Manually prepared 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, "L" for low, or "N" for no.

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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 08/01/2022 and ending 07/31/2023 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

		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	389,144	-959,466	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	423,839	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RHC - CARLINVILLE I	0		40,501		0	10.00
10.01	RHC - GIRARD II	0		9,338		0	10.01
200.00	TOTAL	0	812,983	-909,627	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2023 8:08 am

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CARLINVILLE AREA HOSPITAL	141347	41180	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	41180		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	41180		11/25/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	GIRARD RHC	148532	41180		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)	08/01/2022	07/31/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	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 UCPs, including supplemental UCPs, 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 a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2023 8:08 am

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

		Urban/Rural St	Date of Geogra	
		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)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	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(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, 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. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 12/18/2023 8:08 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2023 8:08 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 12/18/2023 8:08 am

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

		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 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	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 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 12/18/2023 8:08 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

			1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 12/18/2023 8:08 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	400,154	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified 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 program, 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 program, 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 program, 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 program, 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 program, 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 program, 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 program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based 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.			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 12/18/2023 8:08 am

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

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

		1.00	
	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)		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)			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 08/01/2022 To 07/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 12/18/2023 8:08 am

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	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 a nursing program? Column 2: If yes, is the provider 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 programs 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 coinsurance amounts 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	10/27/2023	Y	10/27/2023	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 08/01/2022 To 07/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 12/18/2023 8:08 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	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	Were 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.				Y	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.	PAUL		COURTNEY		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		PCOURTNEY@CAHCARE.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1347	Period: From 08/01/2022 To 07/31/2023	Worksheet S-2 Part II Date/Time Prepared: 12/18/2023 8:08 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHIEF FINANCIAL OFFICER		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

HFS Supplemental Information | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-2 Part IX Date/Time Prepared: 12/18/2023 8:08 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?		Y	3.02
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State		
		1.00		
	STATE MEDICAID FORMS			
10.00	Select the state when using state Medicaid forms.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 12/18/2023 8:08 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
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	31,224.00	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	31,224.00	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	31,224.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
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
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 12/18/2023 8:08 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
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)	591	146	1,301			1.00
2.00	HMO and other (see instructions)	20	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	1,046	0	1,327			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	134			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,637	146	2,762			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,637	146	2,762	0.00	218.70	14.00
15.00	CAH visits	15,724	6,358	33,719			15.00
15.10	REH hours and visits						15.10
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			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	1,962	5,069	14,895	0.00	24.76	26.00
26.01	RHC - GIRARD	527	794	2,757	0.00	3.03	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	246.49	27.00
28.00	Observation Bed Days		102	499			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 12/18/2023 8:08 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
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	180	53	402	1.00
2.00	HMO and other (see instructions)			5	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	180	53	402	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC - CARLINVILLE	0.00					26.00
26.01	RHC - GIRARD	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2022 To 07/31/2023 | Worksheet S-8 | Date/Time Prepared: 12/18/2023 8:08 am

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?			Y		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	
			1.00		2.00	
14.00	RHC/FQHC name, CCN					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 08/01/2022
To 07/31/2023

Worksheet S-8

Date/Time Prepared:
12/18/2023 8:08 am

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 08/01/2022 To 07/31/2023 | Worksheet S-8 | Date/Time Prepared: 12/18/2023 8:08 am

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?			Y		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	
			1.00		2.00	
14.00	RHC/FQHC name, CCN					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 08/01/2022 To 07/31/2023	Worksheet S-8 Date/Time Prepared: 12/18/2023 8:08 am
		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 08/01/2022 To 07/31/2023	Worksheet S-10 Date/Time Prepared: 12/18/2023 8:08 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.451917	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,045,284	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,750,670	5.00
6.00	Medicaid charges	18,757,235	6.00
7.00	Medicaid cost (line 1 times line 6)	8,476,713	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	36,713	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)	102,335	0	102,335	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	46,247	0	46,247	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)	46,247	0	46,247	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,401,198	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	242,535	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	373,131	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,028,067	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	595,197	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	641,444	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	641,444	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,457,808	2,457,808	-198,626	2,259,182	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	916,377	916,377	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	89,521	4,932,781	5,022,302	0	5,022,302	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,508,613	5,003,100	7,511,713	9,167	7,520,880	5.00
7.00	00700	OPERATION OF PLANT	450,066	671,503	1,121,569	0	1,121,569	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	475,188	475,188	0	475,188	8.00
9.00	00900	HOUSEKEEPING	481,316	55,493	536,809	0	536,809	9.00
10.00	01000	DIETARY	312,581	363,869	676,450	0	676,450	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	640,856	79,138	719,994	0	719,994	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	126,308	842,761	969,069	-828,708	140,361	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	422,999	89,113	512,112	0	512,112	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	631,959	48,634	680,593	0	680,593	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,278,579	1,447,510	3,726,089	0	3,726,089	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	895,797	1,816,198	2,711,995	0	2,711,995	50.00
53.00	05300	ANESTHESIOLOGY	0	22,311	22,311	0	22,311	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	874,898	777,859	1,652,757	2,385	1,655,142	54.00
60.00	06000	LABORATORY	1,061,339	1,108,048	2,169,387	0	2,169,387	60.00
65.00	06500	RESPIRATORY THERAPY	641,700	26,822	668,522	0	668,522	65.00
66.00	06600	PHYSICAL THERAPY	1,575,790	83,863	1,659,653	-297,400	1,362,253	66.00
67.00	06700	OCCUPATIONAL THERAPY	275,175	4,074	279,249	0	279,249	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	297,400	297,400	68.00
69.00	06900	ELECTROCARDIOLOGY	141,336	65,492	206,828	0	206,828	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	508,136	508,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	64,634	64,634	320,572	385,206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,432	1,625,633	1,965,065	0	1,965,065	73.00
76.00	03550	BEHAVORIAL HEALTH	184,128	108,615	292,743	-16,029	276,714	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	2,579,999	547,444	3,127,443	-130,439	2,997,004	88.00
88.01	08801	RHC - GIRARD	510,135	63,005	573,140	-37,945	535,195	88.01
90.00	09000	CLINIC	539,424	201,406	740,830	0	740,830	90.00
91.00	09100	EMERGENCY	1,197,513	1,699,239	2,896,752	0	2,896,752	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		544,890	544,890	-544,890	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,759,464	25,226,431	43,985,895	0	43,985,895	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	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	18,759,464	25,226,431	43,985,895	0	43,985,895	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-478,837	1,780,345		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	916,377		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-27,183	4,995,119		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-396,823	7,124,057		5.00
7.00	00700	OPERATION OF PLANT	-3,469	1,118,100		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	475,188		8.00
9.00	00900	HOUSEKEEPING	0	536,809		9.00
10.00	01000	DIETARY	-130,101	546,349		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	719,994		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	140,361		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,944	506,168		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-680,593	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,015,495	2,710,594		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,350,335	1,361,660		50.00
53.00	05300	ANESTHESIOLOGY	0	22,311		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-14,562	1,640,580		54.00
60.00	06000	LABORATORY	0	2,169,387		60.00
65.00	06500	RESPIRATORY THERAPY	0	668,522		65.00
66.00	06600	PHYSICAL THERAPY	-5,742	1,356,511		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	279,249		67.00
68.00	06800	SPEECH PATHOLOGY	0	297,400		68.00
69.00	06900	ELECTROCARDIOLOGY	-61,481	145,347		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	508,136		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	385,206		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-119,796	1,845,269		73.00
76.00	03550	BEHAVORIAL HEALTH	-29,728	246,986		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE	-42	2,996,962		88.00
88.01	08801	RHC - GIRARD	0	535,195		88.01
90.00	09000	CLINIC	-166,724	574,106		90.00
91.00	09100	EMERGENCY	0	2,896,752		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,486,855	39,499,040		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0		194.00
194.01	07951	FUND DEVELOPMENT	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,486,855	39,499,040		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet Non-CMS Wo | Date/Time Prepared: 12/18/2023 8:08 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICE & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	BEHAVORIAL HEALTH	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RHC - CARLINVILLE	08800		88.00
88.01	RHC - GIRARD	08801		88.01
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19000		190.00
194.00	NONREIMBURSABLE COSTS CENTERS	07950		194.00
194.01	FUND DEVELOPMENT	07951		194.01
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A-6 | Date/Time Prepared: 12/18/2023 8:08 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS RECRUITMENT EXPENSES					
1.00	RHC - CARLINVILLE	88.00	0	29,492		1.00
	TOTALS		0	29,492		
	B - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	867,196		1.00
	TOTALS		0	867,196		
	C - INSURANCE EXPENSE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	175,246		1.00
	TOTALS		0	175,246		
	D - SPEECH THERAPY COSTS					
1.00	SPEECH PATHOLOGY	68.00	291,685	5,715		1.00
	TOTALS		291,685	5,715		
	E - INTEREST EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	542,505		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,385		2.00
	TOTALS		0	544,890		
	L - RECLASS RHC ADMIN SALARIES TO ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	213,905	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		213,905	0		
	M - ORTHO IMPLANTABLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	320,572		1.00
	TOTALS		0	320,572		
	N - SOCIAL WORKER SALARIES					
1.00	RHC - CARLINVILLE	88.00	13,363	0		1.00
2.00	RHC - GIRARD	88.01	2,666	0		2.00
	TOTALS		16,029	0		
	O - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	508,136		1.00
	TOTALS		0	508,136		
500.00	Grand Total: Increases		521,619	2,451,247		500.00

RECLASSIFICATIONS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A-6 | Date/Time Prepared: 12/18/2023 8:08 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS RECRUITMENT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,492	0		1.00
	TOTALS		0	29,492			
	B - TO RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	867,196	9		1.00
	TOTALS		0	867,196			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	175,246	0		1.00
	TOTALS		0	175,246			
	D - SPEECH THERAPY COSTS						
1.00	PHYSICAL THERAPY	66.00	291,685	5,715	0		1.00
	TOTALS		291,685	5,715			
	E - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	544,890	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	544,890			
	L - RECLASS RHC ADMIN SALARIES TO ADMIN						
1.00	RHC - CARLINVILLE	88.00	173,294	0	0		1.00
2.00	RHC - GIRARD	88.01	40,611	0	0		2.00
	TOTALS		213,905	0			
	M - ORTHO IMPLANTABLES						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	320,572	0		1.00
	TOTALS		0	320,572			
	N - SOCIAL WORKER SALARIES						
1.00	BEHAVORIAL HEALTH	76.00	16,029	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		16,029	0			
	O - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	508,136	0		1.00
	TOTALS		0	508,136			
500.00	Grand Total: Decreases		521,619	2,451,247			500.00

RECLASSIFICATIONS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 12/18/2023 8:08 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - RECLASS RECRUITMENT EXPENSES								
1.00	RHC - CARLINVILLE	88.00	0	29,492	ADMINISTRATIVE & GENERAL	5.00	0	29,492	1.00
	TOTALS		0	29,492	TOTALS		0	29,492	
	B - TO RECLASS DEPRECIATION EXPENSE								
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	867,196	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	867,196	1.00
	TOTALS		0	867,196	TOTALS		0	867,196	
	C - INSURANCE EXPENSE								
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	175,246	ADMINISTRATIVE & GENERAL	5.00	0	175,246	1.00
	TOTALS		0	175,246	TOTALS		0	175,246	
	D - SPEECH THERAPY COSTS								
1.00	SPEECH PATHOLOGY	68.00	291,685	5,715	PHYSICAL THERAPY	66.00	291,685	5,715	1.00
	TOTALS		291,685	5,715	TOTALS		291,685	5,715	
	E - INTEREST EXPENSE RECLASS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	542,505	INTEREST EXPENSE	113.00	0	544,890	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,385		0.00	0	0	2.00
	TOTALS		0	544,890	TOTALS		0	544,890	
	L - RECLASS RHC ADMIN SALARIES TO ADMIN								
1.00	ADMINISTRATIVE & GENERAL	5.00	213,905	0	RHC - CARLINVILLE	88.00	173,294	0	1.00
2.00		0.00	0	0	RHC - GIRARD	88.01	40,611	0	2.00
	TOTALS		213,905	0	TOTALS		213,905	0	
	M - ORTHO IMPLANTABLES								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	320,572	CENTRAL SERVICE & SUPPLY	14.00	0	320,572	1.00
	TOTALS		0	320,572	TOTALS		0	320,572	
	N - SOCIAL WORKER SALARIES								
1.00	RHC - CARLINVILLE	88.00	13,363	0	BEHAVORIAL HEALTH	76.00	16,029	0	1.00
2.00	RHC - GIRARD	88.01	2,666	0		0.00	0	0	2.00
	TOTALS		16,029	0	TOTALS		16,029	0	
	O - BILLABLE SUPPLIES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	508,136	CENTRAL SERVICE & SUPPLY	14.00	0	508,136	1.00
	TOTALS		0	508,136	TOTALS		0	508,136	
500.00	Grand Total: Increases		521,619	2,451,247	Grand Total: Decreases		521,619	2,451,247	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 12/18/2023 8:08 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	500,172	145,608	0	145,608	0	1.00
2.00	Land Improvements	2,524,060	0	0	0	0	2.00
3.00	Buildings and Fixtures	26,331,066	721,371	0	721,371	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	11,420,382	412,960	0	412,960	1,223,398	6.00
7.00	HIT designated Assets	1,180,327	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,956,007	1,279,939	0	1,279,939	1,223,398	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	41,956,007	1,279,939	0	1,279,939	1,223,398	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	645,780	0	1.00
2.00	Land Improvements	2,524,060	0	2.00
3.00	Buildings and Fixtures	27,052,437	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,609,944	0	6.00
7.00	HIT designated Assets	1,180,327	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,012,548	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	42,012,548	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 12/18/2023 8:08 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,457,808	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,457,808	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,457,808	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,457,808	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 12/18/2023 8:08 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	30,222,276	0	30,222,276	0.719363	126,065	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	11,790,271	0	11,790,271	0.280637	49,181	2.00
3.00	Total (sum of lines 1-2)	42,012,547	0	42,012,547	1.000000	175,246	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	126,065	1,975,472	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	49,181	867,196	0	2.00
3.00	Total (sum of lines 1-2)	0	0	175,246	2,842,668	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-321,192	126,065	0	0	1,780,345	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	49,181	0	0	916,377	2.00
3.00	Total (sum of lines 1-2)	-321,192	175,246	0	0	2,696,722	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A-8 | Date/Time Prepared: 12/18/2023 8:08 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-321,192	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	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	1,184	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	-5,515	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	-2,499,571			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	-126,933	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	-47,285	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,944	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	RADIOLOGY DISCOUNTS	B	-14,562	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	PT PROF FEES	B	-5,742	PHYSICAL THERAPY	66.00	0	33.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet A-8 | Date/Time Prepared: 12/18/2023 8:08 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	PREVIOUS DEBT ISSUANCE COSTS	A	43,119	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.05	SUPPLIES	B	-6,266	OPERATING ROOM	50.00	0	33.05
33.06	AHA & IHA DUES	A	-14,803	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PLANT OPERATION DISCOUNTS	B	-3,469	OPERATION OF PLANT	7.00	0	33.07
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
39.00	MED STAFF RELATIONS	A	-5,821	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	SPECIAL EVENTS - OUTREACH	A	-36,767	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PROMOTIONAL ITEMS - OUTREACH	A	-21,294	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING	A	-192,379	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	TELEPHONE DEPRECIATION	A	-594	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-1,439	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-26,376	CLINIC	90.00	0	44.02
44.03	PATIENT TELEVISION OFFSET	A	-3,130	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	MISC INCOME	B	-9,858	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05	MOB BUILDING RENT	B	-200,170	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.05
44.06	PHARMACY DISCOUNTS	B	0	DRUGS CHARGED TO PATIENTS	73.00	0	44.06
44.07	ER DISCOUNTS	B	0	EMERGENCY	91.00	0	44.07
44.08	LAB DISCOUNTS	B	0	LABORATORY	60.00	0	44.08
44.09	DATA PROCESSING DISCOUNTS	B	0	ADMINISTRATIVE & GENERAL	5.00	0	44.09
44.10	HOSPITALIST REIMBURSEMENT	B	0	EMERGENCY	91.00	0	44.10
44.11	DIETARY CONSULTS	B	-3,168	DIETARY	10.00	0	44.11
45.00	MED SURG DISCOUNTS	B	-341	ADULTS & PEDIATRICS	30.00	0	45.00
45.01	340B PROGRAM	B	-72,511	DRUGS CHARGED TO PATIENTS	73.00	0	45.01
45.02	SCHOOL COUNSELING REVENUE	B	-29,728	BEHAVORIAL HEALTH	76.00	0	45.02
45.03	CRNA COSTS	A	-631,959	NONPHYSICIAN ANESTHETISTS	19.00	0	45.03
45.04	CRNA BENEFITS	A	-27,183	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.04
45.05	EKG PROFESSIONAL FEES	A	-61,481	ELECTROCARDIOLOGY	69.00	0	45.05
45.06	PROFESSIONAL BILLING COSTS	A	-26,752	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	NURSING SERVICE DISCOUNTS	B	0	NURSING ADMINISTRATION	13.00	0	45.07
45.08	CONTRACTED LABOR CRNA	A	-48,634	NONPHYSICIAN ANESTHETISTS	19.00	0	45.08
45.09	CFHC DISCOUNTS	B	-42	RHC - CARLINVILLE	88.00	0	45.09
45.10	SIU ADMIN FEES	A	-80,249	ADMINISTRATIVE & GENERAL	5.00	0	45.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,486,855				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 08/01/2022 To 07/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 12/18/2023 8:08 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	981,869	0	981,869	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	112,803	112,803	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	12,394	12,394	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	889,957	889,957	0	0	0	4.00
5.00	50.00	OPERATING ROOM	1,213,334	1,213,334	0	0	0	5.00
6.00	50.00	OPERATING ROOM	117,402	117,402	0	0	0	6.00
7.00	90.00	CLINIC	6,664	6,664	0	0	0	7.00
8.00	50.00	OPERATING ROOM	13,333	13,333	0	0	0	8.00
9.00	90.00	CLINIC	819	819	0	0	0	9.00
10.00	90.00	CLINIC	119,214	119,214	0	0	0	10.00
11.00	90.00	CLINIC	13,651	13,651	0	0	0	11.00
200.00			3,481,440	2,499,571	981,869		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
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	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	112,803		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	12,394		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	889,957		4.00
5.00	50.00	OPERATING ROOM	0	0	0	1,213,334		5.00
6.00	50.00	OPERATING ROOM	0	0	0	117,402		6.00
7.00	90.00	CLINIC	0	0	0	6,664		7.00
8.00	50.00	OPERATING ROOM	0	0	0	13,333		8.00
9.00	90.00	CLINIC	0	0	0	819		9.00
10.00	90.00	CLINIC	0	0	0	119,214		10.00
11.00	90.00	CLINIC	0	0	0	13,651		11.00
200.00			0	0	0	2,499,571		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B Part I | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,780,345	1,780,345				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	916,377		916,377			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,995,119	3,237	2,816	5,001,172		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,124,057	390,991	229,560	754,838	8,499,446	5.00
7.00	00700	OPERATION OF PLANT	1,118,100	205,139	7,605	124,784	1,455,628	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	475,188	0	0	0	475,188	8.00
9.00	00900	HOUSEKEEPING	536,809	8,384	2,090	133,449	680,732	9.00
10.00	01000	DIETARY	546,349	32,279	6,954	86,666	672,248	10.00
11.00	01100	CAFETERIA	0	32,526	0	0	32,526	11.00
13.00	01300	NURSING ADMINISTRATION	719,994	14,027	630	177,682	912,333	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	140,361	18,590	0	35,020	193,971	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	506,168	8,677	7,808	117,280	639,933	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,776	3,974	0	5,750	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,710,594	251,939	106,043	631,754	3,700,330	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,361,660	118,237	83,918	248,367	1,812,182	50.00
53.00	05300	ANESTHESIOLOGY	22,311	0	0	0	22,311	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,640,580	79,394	297,882	242,572	2,260,428	54.00
60.00	06000	LABORATORY	2,169,387	33,111	29,224	294,265	2,525,987	60.00
65.00	06500	RESPIRATORY THERAPY	668,522	71,841	19,212	177,916	937,491	65.00
66.00	06600	PHYSICAL THERAPY	1,356,511	122,148	16,360	356,028	1,851,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	279,249	11,127	0	76,294	366,670	67.00
68.00	06800	SPEECH PATHOLOGY	297,400	19,579	0	80,872	397,851	68.00
69.00	06900	ELECTROCARDIOLOGY	145,347	68,043	13,136	39,187	265,713	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	508,136	0	1,001	0	509,137	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	385,206	0	0	0	385,206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,845,269	14,476	3,748	94,110	1,957,603	73.00
76.00	03550	BEHAVORIAL HEALTH	246,986	29,627	947	46,607	324,167	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	2,996,962	132,691	66,820	670,983	3,867,456	88.00
88.01	08801	RHC - GIRARD	535,195	0	0	130,918	666,113	88.01
90.00	09000	CLINIC	574,106	57,388	1,889	149,560	782,943	90.00
91.00	09100	EMERGENCY	2,896,752	49,633	14,444	332,020	3,292,849	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 through 117)	39,499,040	1,774,860	916,061	5,001,172	39,493,239	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,114	316	0	4,430	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	1,371	0	0	1,371	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,499,040	1,780,345	916,377	5,001,172	39,499,040	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B Part I Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,499,446					5.00
7.00	00700	OPERATION OF PLANT	399,103	1,854,731				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,287	0	605,475			8.00
9.00	00900	HOUSEKEEPING	186,642	13,168	0	880,542		9.00
10.00	01000	DIETARY	184,316	50,695	0	23,031	930,290	10.00
11.00	01100	CAFETERIA	8,918	51,083	0	23,207	668,989	11.00
13.00	01300	NURSING ADMINISTRATION	250,143	22,029	0	10,008	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	53,183	29,195	0	13,264	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	175,456	13,627	0	6,191	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,577	2,789	0	1,267	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,014,553	395,671	284,840	179,756	261,301	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	496,862	185,692	50,335	84,361	0	50.00
53.00	05300	ANESTHESIOLOGY	6,117	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,762	124,689	55,617	56,647	0	54.00
60.00	06000	LABORATORY	692,573	52,001	0	23,624	0	60.00
65.00	06500	RESPIRATORY THERAPY	257,040	112,827	4,233	51,258	0	65.00
66.00	06600	PHYSICAL THERAPY	507,518	191,835	49,593	87,151	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	100,533	17,475	0	7,939	0	67.00
68.00	06800	SPEECH PATHOLOGY	109,082	30,749	0	13,969	0	68.00
69.00	06900	ELECTROCARDIOLOGY	72,853	106,861	0	48,547	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	139,595	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,615	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,734	22,735	0	10,329	0	73.00
76.00	03550	BEHAVORIAL HEALTH	88,880	46,529	0	21,138	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	1,060,382	208,392	343	94,673	0	88.00
88.01	08801	RHC - GIRARD	182,634	0	0	43,912	0	88.01
90.00	09000	CLINIC	214,667	90,128	0	40,945	0	90.00
91.00	09100	EMERGENCY	902,830	77,948	160,514	35,412	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 through 117)	8,497,855	1,846,118	605,475	876,629	930,290	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,215	6,460	0	2,935	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	376	2,153	0	978	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 through 201)	8,499,446	1,854,731	605,475	880,542	930,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B Part I | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	14.00	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	784,723					11.00
13.00	01300	NURSING ADMINISTRATION	21,272	1,215,785				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	289,613			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,517	0	0	879,724		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	10,290	38,149	0	0	59,822	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	155,516	559,216	0	43,253	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,152	193,186	0	82,198	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,654	59,822	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,616	0	0	254,393	0	54.00
60.00	06000	LABORATORY	84,022	0	0	159,972	0	60.00
65.00	06500	RESPIRATORY THERAPY	40,945	0	0	13,627	0	65.00
66.00	06600	PHYSICAL THERAPY	79,171	0	0	68,475	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,967	0	0	15,070	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,353	0	0	10,981	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,449	0	0	15,766	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,823	0	177,581	17,355	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	112,032	5,464	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,560	131,816	0	48,638	0	73.00
76.00	03550	BEHAVORIAL HEALTH	14,181	0	0	4,074	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	0	46,588	0	88.00
88.01	08801	RHC - GIRARD	0	0	0	6,042	0	88.01
90.00	09000	CLINIC	35,080	0	0	9,854	0	90.00
91.00	09100	EMERGENCY	83,809	293,418	0	75,320	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		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	784,723	1,215,785	289,613	879,724	59,822	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	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	784,723	1,215,785	289,613	879,724	59,822	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B Part I | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	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
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
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	6,594,436	0	6,594,436		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,961,968	0	2,961,968		50.00
53.00	05300	ANESTHESIOLOGY	90,904	0	90,904		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,436,152	0	3,436,152		54.00
60.00	06000	LABORATORY	3,538,179	0	3,538,179		60.00
65.00	06500	RESPIRATORY THERAPY	1,417,421	0	1,417,421		65.00
66.00	06600	PHYSICAL THERAPY	2,834,790	0	2,834,790		66.00
67.00	06700	OCCUPATIONAL THERAPY	525,654	0	525,654		67.00
68.00	06800	SPEECH PATHOLOGY	581,985	0	581,985		68.00
69.00	06900	ELECTROCARDIOLOGY	520,189	0	520,189		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854,491	0	854,491		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	608,317	0	608,317		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,743,415	0	2,743,415		73.00
76.00	03550	BEHAVORIAL HEALTH	498,969	0	498,969		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	5,277,834	0	5,277,834		88.00
88.01	08801	RHC - GIRARD	898,701	0	898,701		88.01
90.00	09000	CLINIC	1,173,617	0	1,173,617		90.00
91.00	09100	EMERGENCY	4,922,100	0	4,922,100		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		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 through 117)	39,479,122	0	39,479,122		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	15,040	0	15,040		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	4,878	0	4,878		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	39,499,040	0	39,499,040		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet Non-CMS Wo | Date/Time Prepared: 12/18/2023 8:08 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	44	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-17	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	20	SQUARE FEET	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	FTE'S	11.00
13.00	NURSING ADMINISTRATION	11	HOURS OF SERVICE	13.00
14.00	CENTRAL SERVICE & SUPPLY	14	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
19.00	NONPHYSICIAN ANESTHETISTS	16	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B Part II Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,237	2,816	6,053	6,053	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	390,991	229,560	620,551	909	5.00
7.00	00700	OPERATION OF PLANT	0	205,139	7,605	212,744	151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,384	2,090	10,474	162	9.00
10.00	01000	DIETARY	0	32,279	6,954	39,233	105	10.00
11.00	01100	CAFETERIA	0	32,526	0	32,526	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,027	630	14,657	215	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	18,590	0	18,590	42	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,677	7,808	16,485	142	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,776	3,974	5,750	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	251,939	106,043	357,982	766	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	118,237	83,918	202,155	301	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,394	297,882	377,276	294	54.00
60.00	06000	LABORATORY	0	33,111	29,224	62,335	357	60.00
65.00	06500	RESPIRATORY THERAPY	0	71,841	19,212	91,053	216	65.00
66.00	06600	PHYSICAL THERAPY	0	122,148	16,360	138,508	431	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,127	0	11,127	92	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,579	0	19,579	98	68.00
69.00	06900	ELECTROCARDIOLOGY	0	68,043	13,136	81,179	47	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,001	1,001	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	14,476	3,748	18,224	114	73.00
76.00	03550	BEHAVORIAL HEALTH	0	29,627	947	30,574	56	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	132,691	66,820	199,511	813	88.00
88.01	08801	RHC - GIRARD	0	0	0	0	159	88.01
90.00	09000	CLINIC	0	57,388	1,889	59,277	181	90.00
91.00	09100	EMERGENCY	0	49,633	14,444	64,077	402	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 through 117)	0	1,774,860	916,061	2,690,921	6,053	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,114	316	4,430	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	1,371	0	1,371	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 through 201)	0	1,780,345	916,377	2,696,722	6,053	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B Part II | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	621,460					5.00
7.00	00700	OPERATION OF PLANT	29,181	242,076				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,526	0	9,526			8.00
9.00	00900	HOUSEKEEPING	13,647	1,719	0	26,002		9.00
10.00	01000	DIETARY	13,477	6,617	0	680	60,112	10.00
11.00	01100	CAFETERIA	652	6,667	0	685	43,228	11.00
13.00	01300	NURSING ADMINISTRATION	18,290	2,875	0	296	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	3,889	3,811	0	392	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,829	1,779	0	183	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	115	364	0	37	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,181	51,642	4,482	5,305	16,884	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,329	24,236	792	2,491	0	50.00
53.00	05300	ANESTHESIOLOGY	447	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,315	16,274	875	1,673	0	54.00
60.00	06000	LABORATORY	50,638	6,787	0	698	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,794	14,726	67	1,514	0	65.00
66.00	06600	PHYSICAL THERAPY	37,108	25,038	780	2,574	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,351	2,281	0	234	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,976	4,013	0	413	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,327	13,947	0	1,434	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,207	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,722	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,244	2,967	0	305	0	73.00
76.00	03550	BEHAVORIAL HEALTH	6,499	6,073	0	624	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	77,538	27,199	5	2,796	0	88.00
88.01	08801	RHC - GIRARD	13,354	0	0	1,297	0	88.01
90.00	09000	CLINIC	15,696	11,763	0	1,209	0	90.00
91.00	09100	EMERGENCY	66,012	10,174	2,525	1,046	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 through 117)	621,344	240,952	9,526	25,886	60,112	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	89	843	0	87	0	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	27	281	0	29	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 through 201)	621,460	242,076	9,526	26,002	60,112	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B Part II Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	14.00	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	83,758					11.00
13.00	01300	NURSING ADMINISTRATION	2,270	38,603				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	26,724			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,752	0	0	36,170		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,098	1,211	0	0	8,575	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,600	17,757	0	1,778		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,100	6,134	0	3,379		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	109		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,897	0	0	10,462		54.00
60.00	06000	LABORATORY	8,968	0	0	6,577		60.00
65.00	06500	RESPIRATORY THERAPY	4,370	0	0	560		65.00
66.00	06600	PHYSICAL THERAPY	8,450	0	0	2,815		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,918	0	0	620		67.00
68.00	06800	SPEECH PATHOLOGY	2,066	0	0	451		68.00
69.00	06900	ELECTROCARDIOLOGY	1,115	0	0	648		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,155	0	16,386	714		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	10,338	225		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,796	4,185	0	2,000		73.00
76.00	03550	BEHAVORIAL HEALTH	1,514	0	0	167		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	0	1,915		88.00
88.01	08801	RHC - GIRARD	0	0	0	248		88.01
90.00	09000	CLINIC	3,744	0	0	405		90.00
91.00	09100	EMERGENCY	8,945	9,316	0	3,097		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 through 117)	83,758	38,603	26,724	36,170	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0		194.01
200.00		Cross Foot Adjustments					8,575	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	83,758	38,603	26,724	36,170	8,575	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B Part II | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	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
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
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	547,377	0	547,377		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	281,917	0	281,917		50.00
53.00	05300	ANESTHESIOLOGY	556	0	556		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	459,066	0	459,066		54.00
60.00	06000	LABORATORY	136,360	0	136,360		60.00
65.00	06500	RESPIRATORY THERAPY	131,300	0	131,300		65.00
66.00	06600	PHYSICAL THERAPY	215,704	0	215,704		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,623	0	23,623		67.00
68.00	06800	SPEECH PATHOLOGY	34,596	0	34,596		68.00
69.00	06900	ELECTROCARDIOLOGY	103,697	0	103,697		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,463	0	29,463		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,285	0	18,285		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,835	0	70,835		73.00
76.00	03550	BEHAVORIAL HEALTH	45,507	0	45,507		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC - CARLINVILLE	309,777	0	309,777		88.00
88.01	08801	RHC - GIRARD	15,058	0	15,058		88.01
90.00	09000	CLINIC	92,275	0	92,275		90.00
91.00	09100	EMERGENCY	165,594	0	165,594		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		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 through 117)	2,680,990	0	2,680,990		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	5,449	0	5,449		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	1,708	0	1,708		194.01
200.00		Cross Foot Adjustments	8,575	0	8,575		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,696,722	0	2,696,722		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B-1 | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	79,202					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		867,198				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144	2,665	18,037,984			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,394	217,240	2,722,518	-8,499,446	30,999,594	5.00
7.00	00700	OPERATION OF PLANT	9,126	7,197	450,066	0	1,455,628	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	475,188	8.00
9.00	00900	HOUSEKEEPING	373	1,978	481,316	0	680,732	9.00
10.00	01000	DIETARY	1,436	6,581	312,581	0	672,248	10.00
11.00	01100	CAFETERIA	1,447	0	0	0	32,526	11.00
13.00	01300	NURSING ADMINISTRATION	624	596	640,856	0	912,333	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	827	0	126,308	0	193,971	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386	7,389	422,999	0	639,933	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	3,761	0	0	5,750	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	100,352	2,278,579	0	3,700,330	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	79,414	895,797	0	1,812,182	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	22,311	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,532	281,895	874,898	0	2,260,428	54.00
60.00	06000	LABORATORY	1,473	27,656	1,061,339	0	2,525,987	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	18,181	641,700	0	937,491	65.00
66.00	06600	PHYSICAL THERAPY	5,434	15,482	1,284,105	0	1,851,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	275,175	0	366,670	67.00
68.00	06800	SPEECH PATHOLOGY	871	0	291,685	0	397,851	68.00
69.00	06900	ELECTROCARDIOLOGY	3,027	12,431	141,336	0	265,713	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	947	0	0	509,137	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	385,206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	644	3,547	339,432	0	1,957,603	73.00
76.00	03550	BEHAVORIAL HEALTH	1,318	896	168,099	0	324,167	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	5,903	63,234	2,420,068	0	3,867,456	88.00
88.01	08801	RHC - GIRARD	0	0	472,190	0	666,113	88.01
90.00	09000	CLINIC	2,553	1,788	539,424	0	782,943	90.00
91.00	09100	EMERGENCY	2,208	13,669	1,197,513	0	3,292,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,958	866,899	18,037,984	-8,499,446	30,993,793	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	299	0	0	4,430	190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	61	0	0	0	1,371	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)	1,780,345	916,377	5,001,172		8,499,446	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.478536	1.056710	0.277258		0.274179	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,053		621,460	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000336		0.020047	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B-1 | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	52,538					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	118,293				8.00
9.00	00900	HOUSEKEEPING	373	0	54,903			9.00
10.00	01000	DIETARY	1,436	0	1,436	41,943		10.00
11.00	01100	CAFETERIA	1,447	0	1,447	30,162	14,719	11.00
13.00	01300	NURSING ADMINISTRATION	624	0	624	0	399	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	827	0	827	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386	0	386	0	835	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79	0	79	0	193	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,208	55,650	11,208	11,781	2,917	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,260	9,834	5,260	0	1,072	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	1,212	54.00
60.00	06000	LABORATORY	1,473	0	1,473	0	1,576	60.00
65.00	06500	RESPIRATORY THERAPY	3,196	827	3,196	0	768	65.00
66.00	06600	PHYSICAL THERAPY	5,434	9,689	5,434	0	1,485	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	495	0	337	67.00
68.00	06800	SPEECH PATHOLOGY	871	0	871	0	363	68.00
69.00	06900	ELECTROCARDIOLOGY	3,027	0	3,027	0	196	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	203	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	667	73.00
76.00	03550	BEHAVORIAL HEALTH	1,318	0	1,318	0	266	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	658	90.00
91.00	09100	EMERGENCY	2,208	31,360	2,208	0	1,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,294	118,293	54,659	41,943	14,719	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	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)	1,854,731	605,475	880,542	930,290	784,723	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.302657	5.118435	16.038140	22.179863	53.313608	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	242,076	9,526	26,002	60,112	83,758	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.607636	0.080529	0.473599	1.433183	5.690468	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet B-1 | Date/Time Prepared: 12/18/2023 8:08 am

		Cost Center Description	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	14.00	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	127,956					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	828,708				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	87,359,271			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,015	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58,855	0	4,295,248	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,332	0	8,162,681	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	263,548	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	25,260,953	0		54.00
60.00	06000	LABORATORY	0	0	15,885,982	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,353,210	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	6,799,950	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,496,568	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,090,428	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,565,600	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	508,136	1,723,452	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	320,572	542,587	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,873	0	4,830,003	0		73.00
76.00	03550	BEHAVORIAL HEALTH	0	0	404,519	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	4,626,375	0		88.00
88.01	08801	RHC - GIRARD	0	0	599,996	0		88.01
90.00	09000	CLINIC	0	0	978,529	0		90.00
91.00	09100	EMERGENCY	30,881	0	7,479,642	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		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 through 117)	127,956	828,708	87,359,271	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
194.00	07950	NONREIMBURSABLE COSTS CENTERS	0	0	0	0		194.00
194.01	07951	FUND DEVELOPMENT	0	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)	1,215,785	289,613	879,724	59,822		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.501586	0.349475	0.010070	598.220000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,603	26,724	36,170	8,575		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.301690	0.032248	0.000414	85.750000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet C Part I Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,594,436		6,594,436	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,961,968		2,961,968	0	0	50.00
53.00	05300	ANESTHESIOLOGY	90,904		90,904	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,436,152		3,436,152	0	0	54.00
60.00	06000	LABORATORY	3,538,179		3,538,179	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,417,421	0	1,417,421	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,834,790	0	2,834,790	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	525,654	0	525,654	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	581,985	0	581,985	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	520,189		520,189	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854,491		854,491	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	608,317		608,317	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,743,415		2,743,415	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	498,969		498,969	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	5,277,834		5,277,834	0	0	88.00
88.01	08801	RHC - GIRARD	898,701		898,701	0	0	88.01
90.00	09000	CLINIC	1,173,617		1,173,617	0	0	90.00
91.00	09100	EMERGENCY	4,922,100		4,922,100	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,048,374		1,048,374		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)	40,527,496	0	40,527,496	0	0	200.00
201.00		Less Observation Beds	1,048,374		1,048,374		0	201.00
202.00		Total (see instructions)	39,479,122	0	39,479,122	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet C Part I Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,159,366		3,159,366			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	142,580	8,020,101	8,162,681	0.362867	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	5,478	258,070	263,548	0.344924	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,088,544	24,172,409	25,260,953	0.136026	0.000000	54.00
60.00	06000	LABORATORY	1,352,582	14,533,400	15,885,982	0.222723	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	236,868	1,116,342	1,353,210	1.047451	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	606,648	6,193,302	6,799,950	0.416884	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	481,649	1,014,919	1,496,568	0.351240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	198,267	892,161	1,090,428	0.533722	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,923	1,540,677	1,565,600	0.332262	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	484,538	1,238,914	1,723,452	0.495802	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	542,587	542,587	1.121142	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,792,536	3,037,467	4,830,003	0.567994	0.000000	73.00
76.00	03550	BEHAVORIAL HEALTH	0	404,519	404,519	1.233487	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	4,626,375	4,626,375			88.00
88.01	08801	RHC - GIRARD	0	599,996	599,996			88.01
90.00	09000	CLINIC	47,031	931,498	978,529	1.199369	0.000000	90.00
91.00	09100	EMERGENCY	237,759	7,241,883	7,479,642	0.658066	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	122,255	1,013,627	1,135,882	0.922960	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)	9,981,024	77,378,247	87,359,271			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,981,024	77,378,247	87,359,271			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet C Part I Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
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 08/01/2022 To 07/31/2023 | Worksheet D Part II Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	281,917	8,162,681	0.034537	65,588	2,265	50.00
53.00	05300	ANESTHESIOLOGY	556	263,548	0.002110	2,913	6	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	459,066	25,260,953	0.018173	408,907	7,431	54.00
60.00	06000	LABORATORY	136,360	15,885,982	0.008584	427,265	3,668	60.00
65.00	06500	RESPIRATORY THERAPY	131,300	1,353,210	0.097029	74,896	7,267	65.00
66.00	06600	PHYSICAL THERAPY	215,704	6,799,950	0.031721	66,579	2,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,623	1,496,568	0.015785	58,441	922	67.00
68.00	06800	SPEECH PATHOLOGY	34,596	1,090,428	0.031727	46,724	1,482	68.00
69.00	06900	ELECTROCARDIOLOGY	103,697	1,565,600	0.066235	12,778	846	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,463	1,723,452	0.017095	169,778	2,902	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,285	542,587	0.033700	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,835	4,830,003	0.014666	551,195	8,084	73.00
76.00	03550	BEHAVORIAL HEALTH	45,507	404,519	0.112497	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	309,777	4,626,375	0.066959	0	0	88.00
88.01	08801	RHC - GIRARD	15,058	599,996	0.025097	0	0	88.01
90.00	09000	CLINIC	92,275	978,529	0.094300	9,090	857	90.00
91.00	09100	EMERGENCY	165,594	7,479,642	0.022139	8,927	198	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	87,021	1,135,882	0.076611	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,220,634	84,199,905		1,903,081	38,040	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part IV | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part IV Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	8,162,681	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	263,548	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	25,260,953	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,885,982	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,353,210	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,799,950	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,496,568	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,090,428	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,565,600	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,723,452	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	542,587	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,830,003	0.000000	73.00
76.00	03550	BEHAVORIAL HEALTH	0	0	0	404,519	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	0	4,626,375	0.000000	88.00
88.01	08801	RHC - GIRARD	0	0	0	599,996	0.000000	88.01
90.00	09000	CLINIC	0	0	0	978,529	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	7,479,642	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,135,882	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	84,199,905		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part IV | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	65,588	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,913	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	408,907	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	427,265	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	74,896	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66,579	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	58,441	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	46,724	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,778	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	169,778	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	551,195	0	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0.000000	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	9,090	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	8,927	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,903,081	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part IV | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		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
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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				95.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part V Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.362867	0	1,782,278	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.344924	0	50,674	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136026	0	7,070,627	0	0	54.00
60.00	06000	LABORATORY	0.222723	0	3,956,190	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.047451	0	315,631	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.416884	0	1,847,577	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351240	0	197,477	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.533722	0	121,233	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.332262	0	517,847	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495802	0	193,491	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.121142	0	133,335	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567994	0	988,722	711	0	73.00
76.00	03550	BEHAVORIAL HEALTH	1.233487	0	374,027	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE						88.00
88.01	08801	RHC - GIRARD						88.01
90.00	09000	CLINIC	1.199369	0	436,465	0	0	90.00
91.00	09100	EMERGENCY	0.658066	0	1,831,081	83	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.922960	0	306,510	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	20,123,165	794	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	20,123,165	794	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part V Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	646,730	0		50.00
53.00	05300	ANESTHESIOLOGY	17,479	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	961,789	0		54.00
60.00	06000	LABORATORY	881,135	0		60.00
65.00	06500	RESPIRATORY THERAPY	330,608	0		65.00
66.00	06600	PHYSICAL THERAPY	770,225	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	69,362	0		67.00
68.00	06800	SPEECH PATHOLOGY	64,705	0		68.00
69.00	06900	ELECTROCARDIOLOGY	172,061	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,933	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	149,487	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	561,588	404		73.00
76.00	03550	BEHAVORIAL HEALTH	461,357	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC - CARLINVILLE				88.00
88.01	08801	RHC - GIRARD				88.01
90.00	09000	CLINIC	523,483	0		90.00
91.00	09100	EMERGENCY	1,204,972	55		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	282,896	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,193,810	459		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,193,810	459		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part IV | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part IV | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	8,162,681	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	263,548	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	25,260,953	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,885,982	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,353,210	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,799,950	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,496,568	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,090,428	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,565,600	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,723,452	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	542,587	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,830,003	0.000000	73.00
76.00	03550	BEHAVORIAL HEALTH	0	0	0	404,519	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0	0	0	4,626,375	0.000000	88.00
88.01	08801	RHC - GIRARD	0	0	0	599,996	0.000000	88.01
90.00	09000	CLINIC	0	0	0	978,529	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	7,479,642	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,135,882	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	84,199,905		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part IV | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,175	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	161,407	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	298,286	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	44,089	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	346,143	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	276,254	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	92,440	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,844	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	87,661	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	462,592	0	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE	0.000000	0	0	0	0	88.00
88.01	08801	RHC - GIRARD	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	1,704	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	6,248	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,782,843	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part IV | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		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
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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				95.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D Part V Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.362867	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.344924	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136026	0	0	0	0	54.00
60.00	06000	LABORATORY	0.222723	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.047451	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.416884	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351240	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.533722	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.332262	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495802	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.121142	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567994	0	0	0	0	73.00
76.00	03550	BEHAVORIAL HEALTH	1.233487	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC - CARLINVILLE						88.00
88.01	08801	RHC - GIRARD						88.01
90.00	09000	CLINIC	1.199369	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.658066	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.922960	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 08/01/2022 To 07/31/2023 | Worksheet D Part V Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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				88.00
88.01	08801	RHC - GIRARD				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 08/01/2022 To 07/31/2023 | Worksheet D-1 | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,261	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,800	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)	1,301	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	538	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)	789	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	15	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	119	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	591	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)	442	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)	604	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	180.16	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	185.56	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,594,436	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,702	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)	22,082	25.00
26.00	Total swing-bed cost (see instructions)	2,812,731	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,781,705	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)	3,781,705	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)	2,100.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,241,656	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)	1,241,656	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D-1 | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	745,534	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,987,190	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
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	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	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 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)	928,615	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,268,968	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	2,197,583	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)	499	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,100.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,048,374	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D-1 | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	547,377	6,594,436	0.083006	1,048,374	87,021	90.00
91.00	Nursing Program cost	0	6,594,436	0.000000	1,048,374	0	91.00
92.00	Allied health cost	0	6,594,436	0.000000	1,048,374	0	92.00
93.00	All other Medical Education	0	6,594,436	0.000000	1,048,374	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D-3 | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		808,385		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.362867	65,588	23,800	50.00
53.00	05300	ANESTHESIOLOGY	0.344924	2,913	1,005	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136026	408,907	55,622	54.00
60.00	06000	LABORATORY	0.222723	427,265	95,162	60.00
65.00	06500	RESPIRATORY THERAPY	1.047451	74,896	78,450	65.00
66.00	06600	PHYSICAL THERAPY	0.416884	66,579	27,756	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351240	58,441	20,527	67.00
68.00	06800	SPEECH PATHOLOGY	0.533722	46,724	24,938	68.00
69.00	06900	ELECTROCARDIOLOGY	0.332262	12,778	4,246	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495802	169,778	84,176	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.121142	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567994	551,195	313,075	73.00
76.00	03550	BEHAVORIAL HEALTH	1.233487	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	1.199369	9,090	10,902	90.00
91.00	09100	EMERGENCY	0.658066	8,927	5,875	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.922960	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,903,081	745,534	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,903,081		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet D-3 | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.362867	3,175	1,152	50.00
53.00	05300	ANESTHESIOLOGY	0.344924	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136026	161,407	21,956	54.00
60.00	06000	LABORATORY	0.222723	298,286	66,435	60.00
65.00	06500	RESPIRATORY THERAPY	1.047451	44,089	46,181	65.00
66.00	06600	PHYSICAL THERAPY	0.416884	346,143	144,301	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351240	276,254	97,031	67.00
68.00	06800	SPEECH PATHOLOGY	0.533722	92,440	49,337	68.00
69.00	06900	ELECTROCARDIOLOGY	0.332262	2,844	945	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.495802	87,661	43,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.121142	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.567994	462,592	262,749	73.00
76.00	03550	BEHAVORIAL HEALTH	1.233487	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	1.199369	1,704	2,044	90.00
91.00	09100	EMERGENCY	0.658066	6,248	4,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.922960	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,782,843	739,705	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,782,843		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1347	Period: From 08/01/2022 To 07/31/2023	Worksheet E Part B Date/Time Prepared: 12/18/2023 8:08 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,194,269	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,194,269	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 (see instructions)	7,266,212	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	54,760	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,080,580	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)	4,130,872	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	4,130,872	30.00
31.00	Primary payer payments	1,171	31.00
32.00	Subtotal (line 30 minus line 31)	4,129,701	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)	312,257	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	202,967	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	312,257	36.00
37.00	Subtotal (see instructions)	4,332,668	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)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,332,668	40.00
40.01	Sequestration adjustment (see instructions)	86,653	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,205,481	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-959,466	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1347	Period: From 08/01/2022 To 07/31/2023	Worksheet E Part B Date/Time Prepared: 12/18/2023 8:08 am
	Title XVIII	Hospital	Cost

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,301,248		5,205,481	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	03/02/2023	91,022		0	3.01
3.02		07/06/2023	27,735		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)		118,757		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,420,005		5,205,481	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		389,144		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		959,466	6.02
7.00	Total Medicare program liability (see instructions)		1,809,149		4,246,015	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 | Period: From 08/01/2022 To 07/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 12/18/2023 8:08 am

Component CCN: 14-Z347 | 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		2,254,946		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	03/02/2023	144,583		0	3.01
3.02		07/06/2023	44,834		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)		189,417		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)		2,444,363		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		423,839		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,868,202		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 08/01/2022 To 07/31/2023	Worksheet E-1 Part II Date/Time Prepared: 12/18/2023 8:08 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1347 | Component CCN: 14-Z347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet E-2 | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,219,559	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 and swing-bed pass-through, see instructions)	747,102	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,046	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)	2,966,661	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,966,661	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)	2,966,661	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	39,924	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,926,737	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,926,737	0	19.00
19.01	Sequestration adjustment (see instructions)	58,535	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,444,363	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	423,839	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1347	Period: From 08/01/2022 To 07/31/2023	Worksheet E-3 Part V Date/Time Prepared: 12/18/2023 8:08 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,987,190	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,987,190	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,007,062	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)	2,007,062	19.00
20.00	Deductibles (exclude professional component)	200,560	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,806,502	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,806,502	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	60,874	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	39,568	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	60,874	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,846,070	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,846,070	30.00
30.01	Sequestration adjustment (see instructions)	36,921	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,420,005	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	389,144	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
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 08/01/2022 To 07/31/2023 | Worksheet G | Date/Time Prepared: 12/18/2023 8:08 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	7,118,624	0	0	0	1.00
2.00	Temporary investments	474,957	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,430,287	0	0	0	4.00
5.00	Other receivable	47,951	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,191,031	0	0	0	6.00
7.00	Inventory	341,665	0	0	0	7.00
8.00	Prepaid expenses	379,840	0	0	0	8.00
9.00	Other current assets	2,581,242	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)	16,183,535	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	645,780	0	0	0	12.00
13.00	Land improvements	2,524,060	0	0	0	13.00
14.00	Accumulated depreciation	-1,553,745	0	0	0	14.00
15.00	Buildings	27,052,437	0	0	0	15.00
16.00	Accumulated depreciation	-17,275,423	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	10,609,944	0	0	0	23.00
24.00	Accumulated depreciation	-7,739,664	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	-1,180,327	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)	14,263,389	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	5,619,935	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	3,271,463	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,891,398	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,338,322	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,687,973	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,441,940	0	0	0	38.00
39.00	Payroll taxes payable	366,763	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,044,720	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	453,341	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,994,737	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,287,650	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)	11,287,650	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,282,387	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,055,935				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)	23,055,935	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,338,322	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet G-1 | Date/Time Prepared: 12/18/2023 8:08 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		21,251,046		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,776,958				2.00
3.00	Total (sum of line 1 and line 2)		23,028,004		0		3.00
4.00	CHANGE IN BENEFICIAL INT IN PERP TR	27,931		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)		27,931		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,055,935		0		11.00
12.00	CHANGE IN BENEFICIAL INT IN PERP TR	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,055,935		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	CHANGE IN BENEFICIAL INT IN PERP TR		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	CHANGE IN BENEFICIAL INT IN PERP TR		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 08/01/2022 To 07/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/18/2023 8:08 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,197,559		2,197,559	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,219,965		1,219,965	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)	3,417,524		3,417,524	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)	3,417,524		3,417,524	17.00
18.00	Ancillary services	6,860,191	0	6,860,191	18.00
19.00	Outpatient services	0	77,629,384	77,629,384	19.00
20.00	RHC - CARLINVILLE	0	4,626,375	4,626,375	20.00
20.01	RHC - GIRARD	0	599,996	599,996	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)	10,277,715	82,855,755	93,133,470	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		43,985,895		29.00
30.00	DEDUCT (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		43,985,895		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1347 | Period: From 08/01/2022 To 07/31/2023 | Worksheet G-3 | Date/Time Prepared: 12/18/2023 8:08 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	93,133,470	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,570,670	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,562,800	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	43,985,895	4.00
5.00	Net income from service to patients (line 3 minus line 4)	576,905	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	116,777	6.00
7.00	Income from investments	428,162	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	19,262	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	126,933	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	226,546	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	0	24.00
24.01	SALES TO NON PATIENTS	17,952	24.01
24.02	BUSINESS INTERUPTION PROCEEDS	0	24.02
24.03	OTHER	40,523	24.03
24.04	340B REVENUE	187,185	24.04
24.05	TRANSFER FROM RELATED PARTY - FOUNDA	0	24.05
24.06	GRANTS	36,713	24.06
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,200,053	25.00
26.00	Total (line 5 plus line 25)	1,776,958	26.00
27.00	LOSS ON INVESTMENTS	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)	1,776,958	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2022 To 07/31/2023 | Worksheet M-1 | Date/Time Prepared: 12/18/2023 8:08 am

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	671,131	0	671,131	0	671,131	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	778,426	0	778,426	0	778,426	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	13,363	13,363	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	953,747	0	953,747	29,492	983,239	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,403,304	0	2,403,304	42,855	2,446,159	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	184,543	184,543	0	184,543	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	114,802	114,802	0	114,802	18.00
19.00	Other Health Care Costs	0	248,099	248,099	0	248,099	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	547,444	547,444	0	547,444	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,403,304	547,444	2,950,748	42,855	2,993,603	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	3,401	0	3,401	0	3,401	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)	3,401	0	3,401	0	3,401	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	173,294	0	173,294	-173,294	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	173,294	0	173,294	-173,294	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,579,999	547,444	3,127,443	-130,439	2,997,004	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2022 To 07/31/2023 | Worksheet M-1 | Date/Time Prepared: 12/18/2023 8:08 am

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	671,131		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	778,426		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	13,363		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	983,239		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,446,159		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	184,543		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	114,802		18.00
19.00	Other Health Care Costs	-42	248,057		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-42	547,402		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-42	2,993,561		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	3,401		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	3,401		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)	-42	2,996,962		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347 | Component CCN: 14-8532 | Period: From 08/01/2022 To 07/31/2023 | Worksheet M-1 | Date/Time Prepared: 12/18/2023 8:08 am

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	259,024	0	259,024	0	259,024	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	35,709	0	35,709	0	35,709	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	2,666	2,666	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	173,122	0	173,122	0	173,122	9.00
10.00	Subtotal (sum of lines 1 through 9)	467,855	0	467,855	2,666	470,521	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	4,023	4,023	0	4,023	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	18,748	18,748	0	18,748	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,771	22,771	0	22,771	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	467,855	22,771	490,626	2,666	493,292	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	1,669	0	1,669	0	1,669	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)	1,669	0	1,669	0	1,669	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	40,234	40,234	0	40,234	29.00
30.00	Administrative Costs	40,611	0	40,611	-40,611	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	40,611	40,234	80,845	-40,611	40,234	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	510,135	63,005	573,140	-37,945	535,195	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1347 | Component CCN: 14-8532 | Period: From 08/01/2022 To 07/31/2023 | Worksheet M-1 | Date/Time Prepared: 12/18/2023 8:08 am

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	259,024		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	35,709		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	2,666		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	173,122		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	470,521		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	4,023		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	18,748		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,771		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	493,292		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	1,669		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	1,669		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	40,234		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	40,234		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	535,195		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2022 To 07/31/2023 | Worksheet M-2 | Date/Time Prepared: 12/18/2023 8:08 am

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	1.36	4,225	3,150	4,284		1.00
2.00	Physician Assistant	0.00	0	1,575	0		2.00
3.00	Nurse Practitioner	5.11	10,234	1,575	8,048		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.47	14,459		12,332	14,459	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	0.16	436			436	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)	6.63	14,895			14,895	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)					2,993,561	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,401	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,996,962	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998865	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)					2,280,872	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,280,872	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,280,872	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,278,283	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,271,844	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1347 | Component CCN: 14-8532 | Period: From 08/01/2022 To 07/31/2023 | Worksheet M-2 | Date/Time Prepared: 12/18/2023 8:08 am

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	0.60	1,281	3,150	1,890		1.00
2.00	Physician Assistant	0.00	0	1,575	0		2.00
3.00	Nurse Practitioner	0.48	1,389	1,575	756		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.08	2,670		2,646	2,670	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	0.03	87			87	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.11	2,757			2,757	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)					493,292	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,669	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					494,961	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996628	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					40,234	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					363,506	15.00
16.00	Total overhead (sum of lines 14 and 15)					403,740	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					403,740	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					402,379	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					895,671	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1347 Component CCN: 14-8530	Period: From 08/01/2022 To 07/31/2023	Worksheet M-3 Date/Time Prepared: 12/18/2023 8:08 am
	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)			5,271,844	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			79,811	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			5,192,033	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			14,895	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)			14,895	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			348.58	7.00
		Calculation of Limit (1)			
		Rate Period 1 (08/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 07/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	293.49	304.64		8.00
9.00	Rate for Program covered visits (see instructions)	293.49	304.64		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	807	1,067		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	236,846	325,051		11.00
12.00	Program covered visits for mental health services (from contractor records)	28	60		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	8,218	18,278		13.00
14.00	Limit adjustment for mental health services (see instructions)	8,218	18,278		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	588,393		16.00
16.01	Total program charges (see instructions)(from contractor's records)		373,092		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		85,615		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		135,021		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.)		339,812		16.04
16.05	Total program cost (see instructions)	0	474,833		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		28,607		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		51,525		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		474,833		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		24,498		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		499,331		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		499,331		26.00
26.01	Sequestration adjustment (see instructions)		9,987		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		448,843		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		40,501		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 08/01/2022 To 07/31/2023	Worksheet M-3 Date/Time Prepared: 12/18/2023 8:08 am
	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)			895,671	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			21,724	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			873,947	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,757	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)			2,757	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			316.99	7.00
		Calculation of Limit (1)			
		Rate Period 1 (08/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 07/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	286.45	297.34		8.00
9.00	Rate for Program covered visits (see instructions)	286.45	297.34		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	218	297		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	62,446	88,310		11.00
12.00	Program covered visits for mental health services (from contractor records)	3	9		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	859	2,676		13.00
14.00	Limit adjustment for mental health services (see instructions)	859	2,676		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	154,291		16.00
16.01	Total program charges (see instructions)(from contractor's records)		89,536		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,684		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,965		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.)		103,606		16.04
16.05	Total program cost (see instructions)	0	118,571		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,819		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		14,094		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		118,571		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,244		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		126,815		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		126,815		26.00
26.01	Sequestration adjustment (see instructions)		2,536		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		114,941		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		9,338		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 VACCINE COST

Provider CCN: 14-1347 | Component CCN: 14-8530 | Period: From 08/01/2022 To 07/31/2023 | Worksheet M-4 | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,446,159	2,446,159	2,446,159	2,446,159	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001153	0.002108	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,820	5,157	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	28,885	8,458	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	31,705	13,615	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,993,561	2,993,561	2,993,561	2,993,561	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,278,283	2,278,283	2,278,283	2,278,283	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010591	0.004548	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	24,129	10,362	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	55,834	23,977	0	0	10.00
11.00	Total number of injections/infusions (from your records)	153	280	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	364.93	85.63	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	50	73	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	18,247	6,251	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		79,811	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		24,498	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1347 | Component CCN: 14-8532 | Period: From 08/01/2022 To 07/31/2023 | Worksheet M-4 | Date/Time Prepared: 12/18/2023 8:08 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	470,521	470,521	470,521	470,521	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001363	0.009540	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	641	4,489	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,209	3,625	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,850	8,114	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	493,292	493,292	493,292	493,292	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	402,379	402,379	402,379	402,379	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007805	0.016449	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,141	6,619	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,991	14,733	0	0	10.00
11.00	Total number of injections/infusions (from your records)	17	120	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	411.24	122.78	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	9	37	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3,701	4,543	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		21,724	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		8,244	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 08/01/2022 To 07/31/2023 | Worksheet M-5 | Date/Time Prepared: 12/18/2023 8:08 am

RHC I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		442,782	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/02/2023	6,061	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)		6,061	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		448,843	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		40,501	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		489,344	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 08/01/2022 To 07/31/2023 | Worksheet M-5 | Date/Time Prepared: 12/18/2023 8:08 am

RHC II | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		114,941	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)		114,941	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		9,338	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		124,279	7.00

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