

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/15/2019 1:15 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 7/15/2019	Time: 1:15 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FERRELL HOSPITAL (14-1324) for the cost reporting period beginning 04/01/2018 and ending 03/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ALISA COLEMAN

Officer or Administrator of Provider(s)

CEO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00		2.00	3.00	4.00	5.00
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	258,590	389,821	0	21,707	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	-13,731	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		207,193		0	10.00
10.01	RURAL HEALTH CLINIC II	0		41,852		0	10.01
200.00	Total	0	244,859	638,866	0	21,707	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1201 PINE STREET	PO Box:		Zip Code: 62930	County: SALINE					1.00
2.00	City: EL DORADO	State: IL								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	FERRELL HOSPITAL	141324	99914	1	02/01/2003	N	0	0	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	FERRELL SWINGBED SNF	142324	99914		02/01/2003	N	0	0	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 OLTG									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	FERRELL HOSPITAL CLINIC	148506	99914		04/01/2009	N	0	0	15.00
15.01	Hospital-Based Health Clinic - RHC II	CARMICLINIC	148588	99914		05/23/2018	N	0	0	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)					04/01/2018	03/31/2019			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					22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N				23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0			24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							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	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	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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							58.00
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 §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 04/01/2018
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Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00	
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00	2.00	3.00			
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	

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	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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					
					0	71.00
	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.					
	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)					
			N		0	75.00
76.00						
						76.00

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	Y	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	Y	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y		108.00
			Physical	Occupational	
			1.00	2.00	
			Speech	Respiratory	
			3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	N	109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/15/2019 1:15 pm	
		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	
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.	N			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.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	157,053	0	0	
		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.	Y	5.02		122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1324		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/15/2019 1:15 pm		
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: DEACONESS HEALTH SYSTEM		Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 600 MARY STREET		PO Box:						142.00	
143.00	City: EVANSVILLE		State: IL		Zip Code: 47710				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	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)								0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					04/01/2018	03/31/2019		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: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/15/2019 1:15 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 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)	Y		3.00
		Y/N 1.00	Type 2.00	Date 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	C	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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/22/2019	N
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		Y 05/22/2019
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
7/15/2019 1:15 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		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.		Y		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.		Y	09/30/2018	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		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.	BLUE AND CO	BLUE AND CO		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500	CBRILL@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
7/15/2019 1:15 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/15/2019 1:15 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	43,728.00	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	43,728.00	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	43,728.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/15/2019 1:15 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,317	46	1,822			1.00
2.00	HMO and other (see instructions)	0	216				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	791	0	873			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	27			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,108	46	2,722			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,108	46	2,722	0.00	122.59	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	10,619	0	29,963	0.00	16.24	26.00
26.01	RURAL HEALTH CLINIC II	0	0	3,266	0.00	1.84	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	140.67	27.00
28.00	Observation Bed Days		22	547			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/15/2019 1:15 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	348	13	509	1.00
2.00 HMO and other (see instructions)			0	60		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	348	13	509	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1324
 Component CCN: 14-8506

 Period:
 From 04/01/2018
 To 03/31/2019

Worksheet S-8

 Date/Time Prepared:
 7/15/2019 1:15 pm

		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1201 PINE STREET			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	EL DORADO		IL 62930	2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		5.00			
Facility hours of operations (1)					
11.00	CLINIC	13:00	17:00	07:00	19:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N 12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y 2 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number		FERRELL HOSPITAL CLINIC		148506 14.00
14.01			ELDORADO FAMILY CLINIC		148507 14.01
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		5.00		Total Visits	
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		SALINE		2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	19:00	07:00	19:00	07:00
		19:00		07:00	19:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1324 Component CCN: 14-8506		Period: From 04/01/2018 To 03/31/2019	Worksheet S-8 Date/Time Prepared: 7/15/2019 1:15 pm
					RHC I	Cost
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00	09:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1324
 Component CCN: 14-8588

 Period:
 From 04/01/2018
 To 03/31/2019

Worksheet S-8

 Date/Time Prepared:
 7/15/2019 1:15 pm

				RHC II		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			1340 HIGHWAY 1, SUITE A		1.00	
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			CARMIL 62821		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	
				from	to	from	to
				1.00	2.00	3.00	4.00
				Tuesday		from	
				1.00		2.00	
11.00	Facility hours of operations (1)			CLINIC		11.00	
				13:00	17:00	07:00	19:00
				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 number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
				Y/N	V	XVIII	XIX
				1.00	2.00	3.00	4.00
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
				County		4.00	
2.00	City, State, ZIP Code, County			WHITE		2.00	
				Tuesday	Wednesday	Thursday	
				to	from	to	from
				6.00	7.00	8.00	9.00
				10.00			
Facility hours of operations (1)							
11.00	CLINIC			19:00		07:00	
				19:00	07:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1324

Period:

Worksheet S-8

Component CCN: 14-8588

From 04/01/2018
To 03/31/2019Date/Time Prepared:
7/15/2019 1:15 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	07:00	19:00	09:00	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet S-10

Date/Time Prepared:
7/15/2019 1:15 pm

			7/15/2019 1:15 pm	
			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.513694	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		915,619	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		2,181,190	5.00
6.00	Medicaid charges		8,813,924	6.00
7.00	Medicaid cost (line 1 times line 6)		4,527,660	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)		1,430,851	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		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,430,851	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
			3.00	
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	447,953	0	447,953
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	230,111	0	230,111
22.00	Payments received from patients for amounts previously written off as charity care	165	0	165
23.00	Cost of charity care (line 21 minus line 22)	229,946	0	229,946
			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)		973,236	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		606,080	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		932,431	27.01
28.00	Non-Medicare bad debt expense (see instructions)		40,805	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		347,312	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		577,258	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,008,109	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A

Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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	CAP REL COSTS-BLDG & FIXT		459,871	459,871	-159,944	299,927	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD		0	0	75,754	75,754	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	326,870	326,870	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	90,851	2,118,231	2,209,082	-3,255	2,205,827	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	686,551	211,133	897,684	602,837	1,500,521	5.01
5.02	00591	OTHER ADMIN AND GENERAL	371,831	2,100,813	2,472,644	-106,504	2,366,140	5.02
6.00	00600	MAINTENANCE & REPAIRS	255,264	332,533	587,797	-236,909	350,888	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	228,067	228,067	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,527	16,527	-4,677	11,850	8.00
9.00	00900	HOUSEKEEPING	235,019	32,787	267,806	-30,669	237,137	9.00
10.00	01000	DIETARY	195,508	139,866	335,374	-128,997	206,377	10.00
11.00	01100	CAFETERIA	0	0	0	117,758	117,758	11.00
13.00	01300	NURSING ADMINISTRATION	260,510	16,227	276,737	-3,113	273,624	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,038	17,875	255,913	-72	255,841	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	304,164	304,164	-1,063	303,101	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,372,616	180,958	1,553,574	-3,810	1,549,764	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	462,414	375,369	837,783	-235,485	602,298	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	538,196	540,618	1,078,814	1,209	1,080,023	54.00
60.00	06000	LABORATORY	540,198	532,840	1,073,038	-253,801	819,237	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	372,017	52,369	424,386	-34,699	389,687	65.00
66.00	06600	PHYSICAL THERAPY	0	580,194	580,194	-50,608	529,586	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	144,449	144,449	520,712	665,161	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	118,824	118,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	228,326	1,267,095	1,495,421	-1,756	1,493,665	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,276,178	877,805	5,153,983	-737,324	4,416,659	88.00
88.01	08801	RURAL HEALTH CLINIC II	195,023	153,971	348,994	16,343	365,337	88.01
90.00	09000	CLINIC	79,332	200,764	280,096	-344	279,752	90.00
90.01	09001	CLINIC - MCLEANSBORO	9,545	24,450	33,995	-12,887	21,108	90.01
90.02	09002	CLINIC - CHF	0	1,637	1,637	-441	1,196	90.02
91.00	09100	EMERGENCY	601,821	1,416,220	2,018,041	-5,776	2,012,265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		607,007	607,007	-45,960	561,047	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,009,238	12,705,773	23,715,011	-49,720	23,665,291	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	49,720	49,720	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	11,009,238	12,705,773	23,715,011	0	23,715,011	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A

Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	299,927	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	75,754	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-10,291	316,579	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,062,024	3,267,851	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,500,521	5.01
5.02	00591	OTHER ADMIN AND GENERAL	1,561,974	3,928,114	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	350,888	6.00
7.00	00700	OPERATION OF PLANT	398,728	626,795	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,850	8.00
9.00	00900	HOUSEKEEPING	0	237,137	9.00
10.00	01000	DIETARY	93,452	299,829	10.00
11.00	01100	CAFETERIA	-36,564	81,194	11.00
13.00	01300	NURSING ADMINISTRATION	49,322	322,946	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,137	241,704	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	303,101	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,549,764	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	602,298	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,080,023	54.00
60.00	06000	LABORATORY	0	819,237	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	389,687	65.00
66.00	06600	PHYSICAL THERAPY	0	529,586	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	665,161	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	118,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,999	1,501,664	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-2,995	4,413,664	88.00
88.01	08801	RURAL HEALTH CLINIC II	-45,716	319,621	88.01
90.00	09000	CLINIC	0	279,752	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	21,108	90.01
90.02	09002	CLINIC - CHF	-1,196	0	90.02
91.00	09100	EMERGENCY	0	2,012,265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-561,047	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,501,553	26,166,844	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,720	192.00
194.00	07950	MARKETING	0	0	194.00
194.01	07951	340B	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	2,501,553	26,216,564	200.00

RECLASSIFICATIONS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
7/15/2019 1:15 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
		A - CAFETERIA COSTS				
1.00	CAFETERIA	11.00		71,028	46,730	1.00
	0			71,028	46,730	
	B - CARMICLINIC RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00		27,784	21,936	1.00
	TOTALS			27,784	21,936	
	C - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		0	33,028	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		0	26,180	2.00
	0			0	59,208	
	D - PROPERTY TAXES					
1.00	INTEREST EXPENSE	113.00		0	3,076	1.00
	0			0	3,076	
	E - PLANT OPERATIONS RECLASS					
1.00	OPERATION OF PLANT	7.00		0	228,067	1.00
	TOTALS			0	228,067	
	F - MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		0	300,690	1.00
	0			0	300,690	
	G - ADMIN RECRUITING					
1.00	RURAL HEALTH CLINIC	88.00		0	19,169	1.00
	0			0	19,169	
	H - EFM BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		0	65,069	1.00
2.00	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01		0	75,754	2.00
3.00	0	0.00		0	0	3.00
	0			0	140,823	
	I - IMPLANT EXPENSE					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		0	118,824	1.00
	0			0	118,824	
	J - BILLABLE OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		0	15,617	1.00
	0			0	15,617	
	K - PT BILLING COSTS					
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01		0	47,722	1.00
	0			0	47,722	
	L - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		0	45,725	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00		0	1,894	2.00
3.00	LABORATORY	60.00		0	1,417	3.00
	TOTALS			0	49,036	
	M - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		0	623,919	1.00
2.00		0.00		0	0	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
11.00		0.00		0	0	11.00
12.00		0.00		0	0	12.00
13.00		0.00		0	0	13.00
14.00		0.00		0	0	14.00
15.00		0.00		0	0	15.00
16.00		0.00		0	0	16.00
17.00		0.00		0	0	17.00
18.00		0.00		0	0	18.00
19.00		0.00		0	0	19.00
20.00		0.00		0	0	20.00
21.00		0.00		0	0	21.00
	0			0	623,919	
	N - RHC RECLASS					
1.00	RURAL HEALTH CLINIC II	88.01		125,299	0	1.00
	TOTALS			125,299	0	

RECLASSIFICATIONS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
7/15/2019 1:15 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	0 - RHC BUSINESS OFFICE RECLASS				
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	436,131	119,309	1.00
	TOTALS		436,131	119,309	
500.00	Grand Total: Increases		660,242	1,794,126	500.00

RECLASSIFICATIONS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
7/15/2019 1:15 pm

		Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COSTS						
1.00	DIETARY	10.00	71,028	46,730	0		1.00
	0		71,028	46,730			
	B - CARMICLINIC RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	27,784	21,936	0		1.00
	TOTALS		27,784	21,936			
	C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.02	0	59,208	13		1.00
2.00	0	0.00	0	0	13		2.00
	0		0	59,208			
	D - PROPERTY TAXES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,076	13		1.00
	0		0	3,076			
	E - PLANT OPERATIONS RECLASS						
1.00	MAINTENANCE & REPAIRS	6.00	0	228,067	0		1.00
	TOTALS		0	228,067			
	F - MME DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	300,690	9		1.00
	0		0	300,690			
	G - ADMIN RECRUITING						
1.00	OTHER ADMIN AND GENERAL	5.02	0	19,169	0		1.00
	0		0	19,169			
	H - EFM BUILDING RENT						
1.00	RURAL HEALTH CLINIC	88.00	0	75,754	10		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	59,236	10		2.00
3.00	CLINIC - MCLEANSBORO	90.01	0	5,833	0		3.00
	0		0	140,823			
	I - IMPLANT EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	118,824	0		1.00
	0		0	118,824			
	J - BILLABLE OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	15,617	0		1.00
	0		0	15,617			
	K - PT BILLING COSTS						
1.00	PHYSICAL THERAPY	66.00	0	47,722	0		1.00
	0		0	47,722			
	L - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	49,036	11		1.00
2.00	0	0.00	0	0	0		2.00
3.00	0	0.00	0	0	0		3.00
	TOTALS		0	49,036			
	M - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,255	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	325	0		2.00
3.00	OTHER ADMIN AND GENERAL	5.02	0	28,127	0		3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	8,842	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	4,677	0		5.00
6.00	HOUSEKEEPING	9.00	0	30,669	0		6.00
7.00	DIETARY	10.00	0	11,239	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	3,113	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	72	0		9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,063	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	3,810	0		11.00
12.00	OPERATING ROOM	50.00	0	235,485	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	685	0		13.00
14.00	LABORATORY	60.00	0	255,218	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	19,082	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	2,886	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,756	0		17.00
18.00	CLINIC	90.00	0	344	0		18.00
19.00	CLINIC - MCLEANSBORO	90.01	0	7,054	0		19.00
20.00	CLINIC - CHF	90.02	0	441	0		20.00
21.00	EMERGENCY	91.00	0	5,776	0		21.00
	0		0	623,919			
	N - RHC RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	125,299	0	0		1.00
	TOTALS		125,299	0			
	O - RHC BUSINESS OFFICE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	436,131	119,309	0		1.00
	TOTALS		436,131	119,309			
500.00	Grand Total: Decreases		660,242	1,794,126			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part I
Date/Time Prepared:
7/15/2019 1:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	183,412	0	0	0	0	1.00	
2.00	Land Improvements	43,892	0	0	0	43,892	2.00	
3.00	Buildings and Fixtures	7,641,509	0	0	0	648,150	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	622,223	0	0	0	622,223	5.00	
6.00	Movable Equipment	2,591,688	1,590,676	0	1,590,676	0	6.00	
7.00	HIT designated Assets	1,589,245	0	0	0	83,059	7.00	
8.00	Subtotal (sum of lines 1-7)	12,671,969	1,590,676	0	1,590,676	1,397,324	8.00	
9.00	Reconciling Items	-2,176,003	2,176,003	0	2,176,003	0	9.00	
10.00	Total (line 8 minus line 9)	14,847,972	-585,327	0	-585,327	1,397,324	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	183,412	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	6,993,359	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	4,182,364	0					6.00
7.00	HIT designated Assets	1,506,186	0					7.00
8.00	Subtotal (sum of lines 1-7)	12,865,321	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	12,865,321	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part II
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	459,871	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	459,871	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	CAP REL COSTS-BLDG & FIXT	0	459,871				1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	459,871				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part III
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,176,771	0	7,176,771	0.557838	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	5,688,550	0	5,688,550	0.442162	0	2.00
3.00	Total (sum of lines 1-2)	12,865,321	0	12,865,321	1.000000	0	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	CAP REL COSTS-BLDG & FIXT	0	0	0	159,181	65,069	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	75,754	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	290,399	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	449,580	140,823	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	CAP REL COSTS-BLDG & FIXT	45,725	0	29,952	0	299,927	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	75,754	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	26,180	0	316,579	2.00
3.00	Total (sum of lines 1-2)	45,725	0	56,132	0	692,260	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8

Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - EFM BLD (chapter 2)			0CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-67,722	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-84,852	DRUGS CHARGED TO PATIENTS	73.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,400	OTHER ADMIN AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-8,412	OTHER ADMIN AND GENERAL	5.02	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	3,560,802			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-36,564	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-2,995	RURAL HEALTH CLINIC	88.00	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-14,137	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	0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - EFM BLD		0	0CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	0NONPHYSICIAN 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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8

Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00			
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-10,291	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LOBBYING DUES	A	-7,229	OTHER ADMIN AND GENERAL	5.02	0	33.00
34.00	PROVIDER TAX OFFSET	A	-493,325	INTEREST EXPENSE	113.00	0	34.00
35.00	CARMI CLINIC MISC REVENUE	B	-45,716	RURAL HEALTH CLINIC II	88.01	0	35.00
35.01	A & G PURCHASE DISCOUNTS	B	-49	OTHER ADMIN AND GENERAL	5.02	0	35.01
35.02	340B OFFSET	A	-191,462	DRUGS CHARGED TO PATIENTS	73.00	0	35.02
35.03	CHF CLINIC OFFSET	A	-1,196	CLINIC - CHF	90.02	0	35.03
35.04	NON ALLOWABLE ADVERTISING	A	-93,899	OTHER ADMIN AND GENERAL	5.02	0	35.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,501,553				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8-1

Date/Time Prepared:
7/15/2019 1:15 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	DHS - HR/EMPLOYEE BENEFITS	1,062,024	0	1.00
2.00	5.02	OTHER ADMIN AND GENERAL	DHS - A&G	1,660,473	120,000	2.00
3.00	7.00	OPERATION OF PLANT	DHS - OPERATION PLANT	398,728	0	3.00
4.00	10.00	DIETARY	DHS - DIETARY	93,452	0	4.00
4.01	13.00	NURSING ADMINISTRATION	DHS - NURSING ADMIN	49,322	0	4.01
4.02	73.00	DRUGS CHARGED TO PATIENTS	DHS - PHARMACY	284,313	0	4.02
4.03	5.02	OTHER ADMIN AND GENERAL	DHS - CASE MANAGEMENT	132,490	0	4.03
4.04	5.01	CASHIERING/ACCOUNTS RECEIVAB	DEACONESS HOSPITAL - EPIC US	44,860	44,860	4.04
4.05	5.02	OTHER ADMIN AND GENERAL	DEACONESS HOSPITAL - SUPPLIE	3,270	3,270	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	DEACONESS HOSPITAL - SUPPLIE	90	90	4.06
4.07	30.00	ADULTS & PEDIATRICS	DEACONESS HOSPITAL - SUPPLIE	2,127	2,127	4.07
4.08	50.00	OPERATING ROOM	DEACONESS HOSPITAL - SUPPLIE	635	635	4.08
4.09	54.00	RADIOLOGY-DIAGNOSTIC	DEACONESS HOSPITAL - SUPPLIE	45	45	4.09
4.10	88.00	RURAL HEALTH CLINIC	DEACONESS HOSPITAL - SUPPLIE	745	745	4.10
4.11	194.00	MARKETING	DEACONESS HOSPITAL - SUPPLIE	3,251	3,251	4.11
4.12	50.00	OPERATING ROOM	DRHS IL - PAIN MGT COVERAGE	97,618	97,618	4.12
4.13	91.00	EMERGENCY	DRHS IL - ER COVERAGE	749,250	749,250	4.13
4.14	5.02	OTHER ADMIN AND GENERAL	DRHS IL - C SUITE SALARY/BEN	393,410	393,410	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,976,103	1,415,301	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
			Name	Percentage of Ownership	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	0.00	DEACONESS HLTH	0.00	6.00
7.00	B	0.00	DEACONESS HOSP	0.00	7.00
8.00	B	0.00	DRHS IL	0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8-1

Date/Time Prepared:
7/15/2019 1:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,062,024	0		1.00
2.00	1,540,473	0		2.00
3.00	398,728	0		3.00
4.00	93,452	0		4.00
4.01	49,322	0		4.01
4.02	284,313	0		4.02
4.03	132,490	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
5.00	3,560,802			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	PROF SVS CO		8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8-2

Date/Time Prepared:
7/15/2019 1:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,351,414	0	1,351,414	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,351,414	0	1,351,414		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	0		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2018 To 03/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2019 1:15 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	125.00	1,550.00	2,198.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	83.03	83.03	62.27	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.52	41.52	31.14			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					10,379	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					128,697	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					136,869	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					275,945	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					275,945	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					275,945	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
7/15/2019 1:15 pm

					Physical Therapy	Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.03	62.27	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					275,945	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					2,647	61.00
62.00	Supplies (see instructions)					5,917	62.00
63.00	Total allowance (sum of lines 57-62)					284,509	63.00
64.00	Total cost of outside supplier services (from your records)					258,330	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2018 To 03/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2019 1:15 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	43.00	891.00	408.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	78.69	78.69	59.02	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.35	39.35	29.51			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					3,384	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					70,113	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					24,080	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					97,577	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					97,577	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					97,577	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2018 To 03/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2019 1:15 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.69	59.02	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					97,577	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					97,577	63.00
64.00	Total cost of outside supplier services (from your records)					89,533	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2018 To 03/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2019 1:15 pm		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						0.00	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	3.00	94.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	75.61	75.61	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.81	37.81	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						227	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						7,107	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						7,334	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						7,334	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						75.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						58,976	22.00
23.00	Total salary equivalency (see instructions)						58,976	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
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					Speech Pathology	Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.61	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						58,976	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						58,976	63.00
64.00	Total cost of outside supplier services (from your records)						6,479	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	BLDG & FIXT - EFM BLD	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	299,927	299,927			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	75,754	0	75,754		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	316,579		316,579		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,267,851	0	1,450	3,270,779	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,500,521	3,886	3,813	199,851	5.01
5.02	00591	OTHER ADMIN AND GENERAL	3,928,114	47,539	0	771,588	5.02
6.00	00600	MAINTENANCE & REPAIRS	350,888	61,168	60,028	87,888	6.00
7.00	00700	OPERATION OF PLANT	626,795	0	1,463	430	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,850	4,839	0	4,748	8.00
9.00	00900	HOUSEKEEPING	237,137	1,619	335	1,687	9.00
10.00	01000	DIETARY	299,829	9,262	0	9,089	10.00
11.00	01100	CAFETERIA	81,194	0	0	49,086	11.00
13.00	01300	NURSING ADMINISTRATION	322,946	493	0	483	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,704	11,365	0	11,153	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	303,101	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,549,764	40,557	0	39,800	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	602,298	15,086	0	14,805	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,080,023	12,747	0	12,509	54.00
60.00	06000	LABORATORY	819,237	5,778	0	5,670	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	389,687	1,674	0	1,642	65.00
66.00	06600	PHYSICAL THERAPY	529,586	5,591	0	5,487	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	665,161	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,824	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,501,664	3,133	0	3,075	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,413,664	38,235	73,956	59,245	88.00
88.01	08801	RURAL HEALTH CLINIC II	319,621	15,693	0	15,400	88.01
90.00	09000	CLINIC	279,752	9,536	0	9,358	90.00
90.01	09001	CLINIC - MCLEANSBORO	21,108	2,659	0	2,609	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,012,265	7,589	0	7,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,166,844	299,927	75,754	316,579	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49,720	0	0	7,246	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,216,564	299,927	75,754	316,579	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
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Cost Center Description			CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.01	5A.01	5.02	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,708,071					5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	4,793,892	4,793,892			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	559,972	125,309	685,281		6.00
7.00	00700	OPERATION OF PLANT	0	628,688	140,686	1,457	770,831	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,437	4,797	16,107	18,156	8.00
9.00	00900	HOUSEKEEPING	0	438,525	98,132	5,723	6,451	9.00
10.00	01000	DIETARY	0	404,198	90,450	30,832	34,755	10.00
11.00	01100	CAFETERIA	0	130,280	29,154	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	821,329	183,795	1,640	1,848	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	444,205	99,403	37,830	42,643	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	303,101	67,827	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	120,788	1,852,354	414,514	135,001	152,178	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	118,381	801,760	179,415	50,217	56,607	50.00
53.00	05300	ANESTHESIOLOGY	44,921	44,921	10,052	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,878	1,607,999	359,833	42,430	47,828	54.00
60.00	06000	LABORATORY	322,368	1,412,743	316,139	19,234	21,681	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	51,110	564,257	126,268	5,571	6,280	65.00
66.00	06600	PHYSICAL THERAPY	83,288	623,952	139,626	18,611	20,979	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,961	724,122	162,042	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,224	129,048	28,878	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	179,838	1,733,758	387,975	10,429	11,756	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	216,435	4,971,233	1,112,438	200,960	226,530	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,777	411,785	92,148	52,236	58,883	88.01
90.00	09000	CLINIC	30,583	371,069	83,037	31,743	35,781	90.00
90.01	09001	CLINIC - MCLEANSBORO	2,068	61,402	13,740	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	115,451	2,303,568	515,486	25,260	28,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,708,071	26,159,598	4,781,144	685,281	770,831	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,966	12,748	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,708,071	26,216,564	4,793,892	685,281	770,831	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	OTHER ADMIN AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,497				8.00
9.00	00900	HOUSEKEEPING	9,744	558,575			9.00
10.00	01000	DIETARY	280	26,015	586,530		10.00
11.00	01100	CAFETERIA	0	0	0	159,434	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,383	0	39,950	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,920	0	14,457	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	40,182	113,910	586,530	8,153	245,718
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,888	42,372	0	4,114	123,974
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,549	35,801	0	12,600	0
60.00	06000	LABORATORY	17	16,229	0	20,848	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	4,701	0	9,656	291,005
66.00	06600	PHYSICAL THERAPY	1,699	15,704	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,800	0	3,692	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	138	169,566	0	29,680	0
88.01	08801	RURAL HEALTH CLINIC II	0	44,076	0	0	0
90.00	09000	CLINIC	0	26,784	0	3,368	0
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0
90.02	09002	CLINIC - CHF	0	0	0	0	0
91.00	09100	EMERGENCY	0	21,314	0	12,916	389,248
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,497	558,575	586,530	159,434	1,049,945
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	MARKETING	0	0	0	0	0
194.01	07951	340B	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	60,497	558,575	586,530	159,434	1,049,945

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	670,458					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	370,928				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,411	0	3,595,951	0	3,595,951	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,466	0	1,310,813	0	1,310,813	50.00
53.00	05300	ANESTHESIOLOGY	17,632	370,928	443,533	0	443,533	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,778	0	2,244,818	0	2,244,818	54.00
60.00	06000	LABORATORY	126,534	0	1,933,425	0	1,933,425	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,061	0	1,027,799	0	1,027,799	65.00
66.00	06600	PHYSICAL THERAPY	32,692	0	853,263	0	853,263	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,143	0	909,307	0	909,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,013	0	161,939	0	161,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,589	0	2,226,999	0	2,226,999	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	84,954	0	6,795,499	0	6,795,499	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,053	0	662,181	0	662,181	88.01
90.00	09000	CLINIC	12,004	0	563,786	0	563,786	90.00
90.01	09001	CLINIC - MCLEANSBORO	812	0	75,954	0	75,954	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	45,316	0	3,341,583	0	3,341,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	670,458	370,928	26,146,850	0	26,146,850	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	69,714	0	69,714	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	670,458	370,928	26,216,564	0	26,216,564	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	BLDG & FIXT - EFM BLD	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,478	0	1,450	2,928 4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	3,886	0	3,813	7,699 5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	47,539	0	46,651	94,190 5.02
6.00	00600	MAINTENANCE & REPAIRS	0	61,168	0	60,028	121,196 6.00
7.00	00700	OPERATION OF PLANT	0	0	1,463	430	1,893 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,839	0	4,748	9,587 8.00
9.00	00900	HOUSEKEEPING	0	1,619	335	1,687	3,641 9.00
10.00	01000	DIETARY	0	9,262	0	9,089	18,351 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	493	0	483	976 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,365	0	11,153	22,518 16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	40,557	0	39,800	80,357 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,086	0	14,805	29,891 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,894	12,747	0	12,509	27,150 54.00
60.00	06000	LABORATORY	1,417	5,778	0	5,670	12,865 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	1,674	0	1,642	3,316 65.00
66.00	06600	PHYSICAL THERAPY	0	5,591	0	5,487	11,078 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	3,133	0	3,075	6,208 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	38,235	73,956	59,245	171,436 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	15,693	0	15,400	31,093 88.01
90.00	09000	CLINIC	0	9,536	0	9,358	18,894 90.00
90.01	09001	CLINIC - MCLEANSBORO	0	2,659	0	2,609	5,268 90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0 90.02
91.00	09100	EMERGENCY	0	7,589	0	7,447	15,036 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,311	299,927	75,754	316,579	695,571 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	MARKETING	0	0	0	0	0 194.00
194.01	07951	340B	0	0	0	0	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)	3,311	299,927	75,754	316,579	695,571 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			4.00	5.01	5.02	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,928					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	179	7,878				5.01
5.02	00591	OTHER ADMIN AND GENERAL	691	0	94,881			5.02
6.00	00600	MAINTENANCE & REPAIRS	79	0	2,480	123,755		6.00
7.00	00700	OPERATION OF PLANT	0	0	2,784	263	4,940	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	95	2,909	116	8.00
9.00	00900	HOUSEKEEPING	177	0	1,942	1,034	41	9.00
10.00	01000	DIETARY	77	0	1,790	5,568	223	10.00
11.00	01100	CAFETERIA	44	0	577	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	445	0	3,638	296	12	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161	0	1,967	6,832	273	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,342	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91	558	8,204	24,380	975	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46	547	3,551	9,069	363	50.00
53.00	05300	ANESTHESIOLOGY	0	207	199	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	140	1,586	7,122	7,662	307	54.00
60.00	06000	LABORATORY	232	1,489	6,257	3,473	139	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	108	236	2,499	1,006	40	65.00
66.00	06600	PHYSICAL THERAPY	0	385	2,763	3,361	134	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	272	3,207	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47	572	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41	831	7,679	1,883	75	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	152	1,000	22,019	36,292	1,454	88.00
88.01	08801	RURAL HEALTH CLINIC II	48	36	1,824	9,433	377	88.01
90.00	09000	CLINIC	37	141	1,643	5,732	229	90.00
90.01	09001	CLINIC - MCLEANSBORO	30	10	272	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	144	533	10,203	4,562	182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,922	7,878	94,629	123,755	4,940	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6	0	252	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	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)	2,928	7,878	94,881	123,755	4,940	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	OTHER ADMIN AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,707				8.00
9.00	00900	HOUSEKEEPING	2,047	8,882			9.00
10.00	01000	DIETARY	59	414	26,482		10.00
11.00	01100	CAFETERIA	0	0	0	621	11.00
13.00	01300	NURSING ADMINISTRATION	0	22	0	156	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	508	0	56	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,439	1,811	26,482	32	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,237	674	0	16	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	535	569	0	49	54.00
60.00	06000	LABORATORY	4	258	0	81	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	75	0	38	65.00
66.00	06600	PHYSICAL THERAPY	357	250	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	140	0	14	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	29	2,695	0	116	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	701	0	0	88.01
90.00	09000	CLINIC	0	426	0	13	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	339	0	50	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,707	8,882	26,482	621	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,707	8,882	26,482	621	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,315					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,342				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,286		154,913	0	154,913	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,240		48,289	0	48,289	50.00
53.00	05300	ANESTHESIOLOGY	850		1,256	0	1,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,539		51,659	0	51,659	54.00
60.00	06000	LABORATORY	6,100		30,898	0	30,898	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	967		9,822	0	9,822	65.00
66.00	06600	PHYSICAL THERAPY	1,576		19,904	0	19,904	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,116		4,595	0	4,595	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	193		812	0	812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,403		20,274	0	20,274	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,095		239,288	0	239,288	88.00
88.01	08801	RURAL HEALTH CLINIC II	147		43,659	0	43,659	88.01
90.00	09000	CLINIC	579		27,694	0	27,694	90.00
90.01	09001	CLINIC - MCLEANSBORO	39		5,619	0	5,619	90.01
90.02	09002	CLINIC - CHF	0		0	0	0	90.02
91.00	09100	EMERGENCY	2,185		35,289	0	35,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,315	0	693,971	0	693,971	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		258	0	258	192.00
194.00	07950	MARKETING	0		0	0	0	194.00
194.01	07951	340B	0		0	0	0	194.01
200.00		Cross Foot Adjustments		1,342	1,342	0	1,342	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,315	1,342	695,571	0	695,571	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (FTE'S)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - EFM BLD (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	65,766				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	4,972			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			70,738		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	324	0	324	13,993	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	852	0	852	855	50,899,669
5.02	00591	OTHER ADMIN AND GENERAL	10,424	0	10,424	3,301	0
6.00	00600	MAINTENANCE & REPAIRS	13,413	0	13,413	376	0
7.00	00700	OPERATION OF PLANT	0	96	96	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	1,061	0	1,061	0	0
9.00	00900	HOUSEKEEPING	355	22	377	846	0
10.00	01000	DIETARY	2,031	0	2,031	368	0
11.00	01100	CAFETERIA	0	0	0	210	0
13.00	01300	NURSING ADMINISTRATION	108	0	108	2,128	0
16.00	01600	MEDICAL RECORDS & LIBRARY	2,492	0	2,492	770	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,893	0	8,893	434	3,599,373
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,308	0	3,308	219	3,527,655
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,338,602
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,795	0	2,795	671	10,307,473
60.00	06000	LABORATORY	1,267	0	1,267	1,111	9,606,295
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	367	0	367	514	1,523,033
66.00	06600	PHYSICAL THERAPY	1,226	0	1,226	0	2,481,907
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,756,984
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	304,678
73.00	07300	DRUGS CHARGED TO PATIENTS	687	0	687	197	5,359,026
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,384	4,854	13,238	726	6,449,576
88.01	08801	RURAL HEALTH CLINIC II	3,441	0	3,441	228	231,750
90.00	09000	CLINIC	2,091	0	2,091	179	911,350
90.01	09001	CLINIC - MCLEANSBORO	583	0	583	141	61,632
90.02	09002	CLINIC - CHF	0	0	0	0	0
91.00	09100	EMERGENCY	1,664	0	1,664	688	3,440,335
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,766	4,972	70,738	13,962	50,899,669
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	31	0
194.00	07950	MARKETING	0	0	0	0	0
194.01	07951	340B	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	299,927	75,754	316,579	3,270,779	1,708,071
203.00		Unit cost multiplier (Wkst. B, Part I)	4.560518	15.236122	4.475374	233.743943	0.033558
204.00		Cost to be allocated (per Wkst. B, Part II)				2,928	7,878
205.00		Unit cost multiplier (Wkst. B, Part II)				0.209247	0.000155
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

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Cost Center Description		Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A.02	5.02	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	OTHER ADMIN AND GENERAL	-4,793,892	21,422,672			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	559,972	45,142		6.00
7.00	00700	OPERATION OF PLANT	0	628,688	96	45,046	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,437	1,061	191,311	8.00
9.00	00900	HOUSEKEEPING	0	438,525	377	30,815	9.00
10.00	01000	DIETARY	0	404,198	2,031	885	10.00
11.00	01100	CAFETERIA	0	130,280	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	821,329	108	108	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	444,205	2,492	2,492	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	303,101	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,852,354	8,893	8,893	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	801,760	3,308	3,308	50.00
53.00	05300	ANESTHESIOLOGY	0	44,921	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,607,999	2,795	2,795	54.00
60.00	06000	LABORATORY	0	1,412,743	1,267	1,267	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	564,257	367	367	65.00
66.00	06600	PHYSICAL THERAPY	0	623,952	1,226	1,226	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	724,122	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	129,048	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,733,758	687	687	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,971,233	13,238	13,238	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	411,785	3,441	3,441	88.01
90.00	09000	CLINIC	0	371,069	2,091	2,091	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	61,402	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	2,303,568	1,664	1,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,793,892	21,365,706	45,142	45,046	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,966	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
194.01	07951	340B	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)		4,793,892	685,281	770,831	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.223777	15.180564	17.112085	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		94,881	123,755	4,940	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004429	2.741460	0.109666	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: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	43,608					9.00
10.00	01000	DIETARY	2,031	1,822				10.00
11.00	01100	CAFETERIA	0	0	176,654			11.00
13.00	01300	NURSING ADMINISTRATION	108	0	44,263	38,602		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,492	0	16,019	0	50,899,669	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,893	1,822	9,034	9,034	3,599,373	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,308	0	4,558	4,558	3,527,655	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,338,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,795	0	13,961	0	10,307,473	54.00
60.00	06000	LABORATORY	1,267	0	23,100	0	9,606,295	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	367	0	10,699	10,699	1,523,033	65.00
66.00	06600	PHYSICAL THERAPY	1,226	0	0	0	2,481,907	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,756,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	304,678	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	687	0	4,091	0	5,359,026	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	13,238	0	32,886	0	6,449,576	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,441	0	0	0	231,750	88.01
90.00	09000	CLINIC	2,091	0	3,732	0	911,350	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	61,632	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,664	0	14,311	14,311	3,440,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,608	1,822	176,654	38,602	50,899,669	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	340B	0	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)	558,575	586,530	159,434	1,049,945	670,458	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.809003	321.915477	0.902521	27.199238	0.013172	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,882	26,482	621	5,545	32,315	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.203678	14.534577	0.003515	0.143645	0.000635	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: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.01
5.02	00591	OTHER ADMIN AND GENERAL	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
90.00	09000	CLINIC	90.00
90.01	09001	CLINIC - MCLEANSBORO	90.01
90.02	09002	CLINIC - CHF	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	340B	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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
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				Title XVIII	Hospital	Cost			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,595,951		3,595,951	0	0	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,310,813		1,310,813	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	443,533		443,533	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,244,818		2,244,818	0	0	54.00	
60.00	06000	LABORATORY	1,933,425		1,933,425	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	1,027,799	0	1,027,799	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	853,263	0	853,263	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	909,307		909,307	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	161,939		161,939	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,226,999		2,226,999	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,795,499		6,795,499	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	662,181		662,181	0	0	88.01	
90.00	09000	CLINIC	563,786		563,786	0	0	90.00	
90.01	09001	CLINIC - MCLEANSBORO	75,954		75,954	0	0	90.01	
90.02	09002	CLINIC - CHF	0		0	0	0	90.02	
91.00	09100	EMERGENCY	3,341,583		3,341,583	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	606,010		606,010		0	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	26,752,860	0	26,752,860	0	0	200.00	
201.00		Less Observation Beds	606,010		606,010		0	201.00	
202.00		Total (see instructions)	26,146,850	0	26,146,850	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
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			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,930,850		2,930,850		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,885,113	1,642,542	3,527,655	0.371582	50.00
53.00	05300	ANESTHESIOLOGY	53,577	1,285,025	1,338,602	0.331340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,895	9,787,578	10,307,473	0.217785	54.00
60.00	06000	LABORATORY	986,383	8,619,912	9,606,295	0.201266	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	524,071	998,962	1,523,033	0.674837	65.00
66.00	06600	PHYSICAL THERAPY	895,797	1,586,110	2,481,907	0.343793	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	736,828	1,020,156	1,756,984	0.517539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,875	277,803	304,678	0.531509	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,570,506	3,788,520	5,359,026	0.415560	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,449,576	6,449,576		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	231,750	231,750		88.01
90.00	09000	CLINIC	0	911,350	911,350	0.618627	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	61,632	61,632	1.232379	90.01
90.02	09002	CLINIC - CHF	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	106,333	3,334,002	3,440,335	0.971296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,078	636,445	668,523	0.906491	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	10,268,306	40,631,363	50,899,669		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,268,306	40,631,363	50,899,669		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
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To 03/31/2019Worksheet C
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 CLINIC - MCLEANSBORO	0.000000			90.01
90.02	09002 CLINIC - CHF	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
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To 03/31/2019Worksheet C
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,930,850		2,930,850		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,885,113	1,642,542	3,527,655	0.371582	0.000000
53.00	05300	ANESTHESIOLOGY	53,577	1,285,025	1,338,602	0.331340	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,895	9,787,578	10,307,473	0.217785	0.000000
60.00	06000	LABORATORY	986,383	8,619,912	9,606,295	0.201266	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	524,071	998,962	1,523,033	0.674837	0.000000
66.00	06600	PHYSICAL THERAPY	895,797	1,586,110	2,481,907	0.343793	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	736,828	1,020,156	1,756,984	0.517539	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,875	277,803	304,678	0.531509	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,570,506	3,788,520	5,359,026	0.415560	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,449,576	6,449,576	1.053635	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	231,750	231,750	2.857307	0.000000
90.00	09000	CLINIC	0	911,350	911,350	0.618627	0.000000
90.01	09001	CLINIC - MCLEANSBORO	0	61,632	61,632	1.232379	0.000000
90.02	09002	CLINIC - CHF	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	106,333	3,334,002	3,440,335	0.971296	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,078	636,445	668,523	0.906491	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	10,268,306	40,631,363	50,899,669		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,268,306	40,631,363	50,899,669		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000			88.01
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 CLINIC - MCLEANSBORO	0.000000			90.01
90.02	09002 CLINIC - CHF	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
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: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part II
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			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	48,289	3,527,655	0.013689	72,395	991
53.00	05300	ANESTHESIOLOGY	1,256	1,338,602	0.000938	16,643	16
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,659	10,307,473	0.005012	220,293	1,104
60.00	06000	LABORATORY	30,898	9,606,295	0.003216	555,474	1,786
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	9,822	1,523,033	0.006449	312,839	2,017
66.00	06600	PHYSICAL THERAPY	19,904	2,481,907	0.008020	152,155	1,220
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,595	1,756,984	0.002615	450,804	1,179
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	812	304,678	0.002665	20,425	54
73.00	07300	DRUGS CHARGED TO PATIENTS	20,274	5,359,026	0.003783	871,203	3,296
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	239,288	6,449,576	0.037101	0	0
88.01	08801	RURAL HEALTH CLINIC II	43,659	231,750	0.188388	0	0
90.00	09000	CLINIC	27,694	911,350	0.030388	0	0
90.01	09001	CLINIC - MCLEANSBORO	5,619	61,632	0.091170	0	0
90.02	09002	CLINIC - CHF	0	0	0.000000	0	0
91.00	09100	EMERGENCY	35,289	3,440,335	0.010257	1,939	20
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	26,107	668,523	0.039052	0	0
200.00		Total (lines 50 through 199)	565,165	47,968,819		2,674,170	11,683

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet D
Part IV
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	370,928	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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0 90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0 90.02
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	370,928	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet D
Part IV
Date/Time Prepared:
7/15/2019 1:15 pm

				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)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	3,527,655	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	370,928	0	1,338,602	0.277101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,307,473	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,606,295	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,523,033	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,481,907	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,756,984	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	304,678	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,359,026	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,449,576	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	231,750	0.000000	88.01
90.00	09000	CLINIC	0	0	0	911,350	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	61,632	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	3,440,335	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	668,523	0.000000	92.00
200.00		Total (lines 50 through 199)	0	370,928	0	47,968,819		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet D
Part IV
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	72,395	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	16,643	4,612	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	220,293	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	555,474	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	312,839	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	152,155	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	450,804	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	20,425	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	871,203	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	1,939	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,674,170	4,612	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
7/15/2019 1:15 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.371582	0	1,490,941	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.331340	0	508,173	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217785	0	4,031,654	0	0	0	54.00
60.00	06000	LABORATORY	0.201266	0	4,541,623	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.674837	0	482,962	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.343793	0	731,816	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.517539	0	553,341	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531509	0	144,312	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415560	0	1,930,530	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000					0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000					0	88.01
90.00	09000	CLINIC	0.618627	0	804,100	0	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	1.232379	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.971296	0	1,231,831	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.906491	0	331,947	0	0	0	92.00
200.00		Subtotal (see instructions)		0	16,783,230	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	16,783,230	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1324		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part V Date/Time Prepared: 7/15/2019 1:15 pm		
				Title XVIII		Hospital		Cost		
Cost Center Description			Costs							
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)						
			6.00	7.00						
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	554,007	0						50.00
53.00	05300	ANESTHESIOLOGY	168,378	0						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	878,034	0						54.00
60.00	06000	LABORATORY	914,074	0						60.00
64.00	06400	INTRAVENOUS THERAPY	0	0						64.00
65.00	06500	RESPIRATORY THERAPY	325,921	0						65.00
66.00	06600	PHYSICAL THERAPY	251,593	0						66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	286,376	0						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,703	0						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	802,251	0						73.00
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	0	0						88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0						88.01
90.00	09000	CLINIC	497,438	0						90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0						90.01
90.02	09002	CLINIC - CHF	0	0						90.02
91.00	09100	EMERGENCY	1,196,473	0						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	300,907	0						92.00
200.00		Subtotal (see instructions)	6,252,155	0						200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0							201.00
202.00		Net Charges (line 200 - line 201)	6,252,155	0						202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:

Worksheet D

Component CCN: 14-Z324

From 04/01/2018
To 03/31/2019Part V
Date/Time Prepared:
7/15/2019 1:15 pm

			Title XVIII	Swing Beds - SNF		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.371582	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.331340	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217785	0	0	0	0	54.00
60.00	06000	LABORATORY	0.201266	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.674837	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.343793	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.517539	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531509	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415560	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.618627	0	0	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	1.232379	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.971296	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.906491	0	0	0	0	92.00
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: 14-1324

Period:

Worksheet D

Component CCN: 14-Z324

From 04/01/2018
To 03/31/2019Part V
Date/Time Prepared:
7/15/2019 1:15 pm

			Title XVIII		Swing Beds - SNF		Cost		
	Cost Center Description		Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0					88.01
90.00	09000	CLINIC	0	0					90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0					90.01
90.02	09002	CLINIC - CHF	0	0					90.02
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
7/15/2019 1:15 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.371582	0	126,063	0	0
53.00	05300	ANESTHESIOLOGY	0.331340	0	15,088	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217785	0	368,176	0	0
60.00	06000	LABORATORY	0.201266	0	150,098	0	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.674837	0	23,056	0	0
66.00	06600	PHYSICAL THERAPY	0.343793	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.517539	0	30,672	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531509	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415560	0	75,491	0	0
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.053635				0
88.01	08801	RURAL HEALTH CLINIC II	2.857307				0
90.00	09000	CLINIC	0.618627	0	0	0	0
90.01	09001	CLINIC - MCLEANSBORO	1.232379	0	0	0	0
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.971296	0	158,516	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.906491	0	21,179	0	0
200.00		Subtotal (see instructions)		0	968,339	0	0
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00		Net Charges (line 200 - line 201)		0	968,339	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1324		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part V Date/Time Prepared: 7/15/2019 1:15 pm	
				Title XIX		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	46,843	0					50.00
53.00	05300	ANESTHESIOLOGY	4,999	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,183	0					54.00
60.00	06000	LABORATORY	30,210	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	15,559	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,874	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,371	0					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0					88.01
90.00	09000	CLINIC	0	0					90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0					90.01
90.02	09002	CLINIC - CHF	0	0					90.02
91.00	09100	EMERGENCY	153,966	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,199	0					92.00
200.00		Subtotal (see instructions)	398,204	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	398,204	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 7/15/2019 1:15 pm	
Title XVIII		Hospital	Cost		
Cost Center Description		1.00			
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,269			1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,369			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)	1,822			4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0			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)	873			6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0			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)	27			8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,317			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)	0			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)	791			11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0			12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0			13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0			14.00
15.00	Total nursery days (title V or XIX only)	0			15.00
16.00	Nursery days (title V or XIX only)	0			16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	155.41			19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.41			20.00
21.00	Total general inpatient routine service cost (see instructions)	3,595,951			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)	0			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)	4,196			25.00
26.00	Total swing-bed cost (see instructions)	971,375			26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,624,576			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)	2,624,576			37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,107.88			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,459,078			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)	1,459,078			41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,063,700	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,522,778	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					876,333	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					876,333	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)					547	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,107.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					606,010	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
7/15/2019 1:15 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	154,913	3,595,951	0.043080	606,010	26,107	90.00
91.00	Nursing School cost	0	3,595,951	0.000000	606,010	0	91.00
92.00	Allied health cost	0	3,595,951	0.000000	606,010	0	92.00
93.00	All other Medical Education	0	3,595,951	0.000000	606,010	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 7/15/2019 1:15 pm	
		Title XIX	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)			3,269	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,369	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)			1,822	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	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)			873	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	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)			27	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			46	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)			0	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)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,595,951	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)			0	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)			4,196	25.00
26.00	Total swing-bed cost (see instructions)			971,375	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,624,576	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)			2,624,576	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,107.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			50,962	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)			50,962	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital 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)						59,226 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						110,188 49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge						0.00 55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 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)						547 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,107.88 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						606,010 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		Title XIX		Hospital		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	154,913	3,595,951	0.043080	606,010	26,107	90.00
91.00	Nursing School cost	0	3,595,951	0.000000	606,010	0	91.00
92.00	Allied health cost	0	3,595,951	0.000000	606,010	0	92.00
93.00	All other Medical Education	0	3,595,951	0.000000	606,010	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 7/15/2019 1:15 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,797,705		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.371582	72,395	26,901	50.00
53.00	05300 ANESTHESIOLOGY	0.331340	16,643	5,514	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217785	220,293	47,977	54.00
60.00	06000 LABORATORY	0.201266	555,474	111,798	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.674837	312,839	211,115	65.00
66.00	06600 PHYSICAL THERAPY	0.343793	152,155	52,310	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.517539	450,804	233,309	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.531509	20,425	10,856	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.415560	871,203	362,037	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	0.618627	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	1.232379	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.971296	1,939	1,883	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.906491	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,674,170	1,063,700	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,674,170		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 7/15/2019 1:15 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.371582	5,039	1,872	50.00
53.00	05300 ANESTHESIOLOGY	0.331340	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217785	38,836	8,458	54.00
60.00	06000 LABORATORY	0.201266	108,508	21,839	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.674837	103,764	70,024	65.00
66.00	06600 PHYSICAL THERAPY	0.343793	610,653	209,938	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.517539	135,423	70,087	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.531509	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.415560	281,249	116,876	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	0.618627	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	1.232379	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.971296	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.906491	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,283,472	499,094	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)		1,283,472		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 7/15/2019 1:15 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		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		62,790		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.371582	6,048	2,247	50.00
53.00	05300 ANESTHESIOLOGY	0.331340	948	314	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217785	33,705	7,340	54.00
60.00	06000 LABORATORY	0.201266	42,270	8,508	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.674837	10,932	7,377	65.00
66.00	06600 PHYSICAL THERAPY	0.343793	3,350	1,152	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.517539	13,489	6,981	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.531509	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.415560	43,270	17,981	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.053635	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	2.857307	0	0	88.01
90.00	09000 CLINIC	0.618627	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	1.232379	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.971296	7,542	7,326	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.906491	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		161,554	59,226	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		161,554		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 7/15/2019 1:15 pm	
Cost Center Description		Title XIX	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.371582	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.331340	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217785	0	0	54.00
60.00	06000 LABORATORY	0.201266	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.674837	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.343793	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.517539	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.531509	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.415560	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.053635	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	2.857307	0	0	88.01
90.00	09000 CLINIC	0.618627	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	1.232379	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.971296	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.906491	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 7/15/2019 1:15 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,252,155 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,252,155 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)			6,314,677 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)			0 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,481,762 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,832,915 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,832,915 30.00
31.00	Primary payer payments			161 31.00
32.00	Subtotal (line 30 minus line 31)			3,832,754 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)			785,914 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			510,844 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			669,258 36.00
37.00	Subtotal (see instructions)			4,343,598 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			4,343,598 40.00
40.01	Sequestration adjustment (see instructions)			86,872 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			3,866,905 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			389,821 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet E-1
Part I
Date/Time Prepared:
7/15/2019 1:15 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,206,977		4,092,226	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	05/24/2018	10,168	05/24/2018	13,996	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	03/28/2019	196,239	03/28/2019	239,317	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)		-186,071		-225,321	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)		2,020,906		3,866,905	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		258,590		389,821	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,279,496		4,256,726	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: 14-1324

Period:

Worksheet E-1

Component CCN: 14-Z324

From 04/01/2018
To 03/31/2019Part I
Date/Time Prepared:
7/15/2019 1:15 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,352,117		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	03/28/2019	12,822		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		12,822		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)		1,364,939		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		13,731		0	6.02
7.00	Total Medicare program liability (see instructions)		1,351,208		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: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet E-1 Part II Date/Time Prepared: 7/15/2019 1:15 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1324

Period:

Worksheet E-2

Component CCN: 14-Z324

From 04/01/2018

Date/Time Prepared:

To 03/31/2019

7/15/2019 1:15 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		885,096	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		504,085	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		791	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)		1,389,181	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,389,181	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)		1,389,181	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		10,397	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,378,784	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)		1,378,784	0	19.00
19.01	Sequestration adjustment (see instructions)		27,576	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,364,939	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-13,731	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2018 To 03/31/2019	Worksheet E-2 Date/Time Prepared: 7/15/2019 1:15 pm
		Title XIX	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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	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: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet E-3 Part V Date/Time Prepared: 7/15/2019 1:15 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,522,778 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,522,778 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,548,006 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)			2,548,006 19.00
20.00	Deductibles (exclude professional component)			316,556 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,231,450 22.00
23.00	Coinsurance			670 23.00
24.00	Subtotal (line 22 minus line 23)			2,230,780 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			146,517 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			95,236 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			113,593 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,326,016 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			2,326,016 30.00
30.01	Sequestration adjustment (see instructions)			46,520 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			2,020,906 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			258,590 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet E-3
Part VII
Date/Time Prepared:
7/15/2019 1:15 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		110,188		1.00
2.00	Medical and other services			398,204	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		111,290	402,186	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		111,290	402,186	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		161,554	968,339	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		161,554	968,339	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		161,554	968,339	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		50,264	566,153	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		111,290	402,186	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		111,290	402,186	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		111,290	402,186	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		111,290	402,186	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		111,290	402,186	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		111,290	402,186	40.00
41.00	Interim payments		107,377	384,392	41.00
42.00	Balance due provider/program (line 40 minus line 41)		3,913	17,794	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet G

Date/Time Prepared:
7/15/2019 1:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	782,122	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,568,703	0	0	0	4.00
5.00	Other receivable	663,535	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	301,586	0	0	0	7.00
8.00	Prepaid expenses	328,183	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,644,129	0	0	0	11.00
FIXED ASSETS						
12.00	Land	183,412	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-42,848	0	0	0	14.00
15.00	Buildings	6,993,359	0	0	0	15.00
16.00	Accumulated depreciation	-1,656,320	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,688,550	0	0	0	23.00
24.00	Accumulated depreciation	-4,392,189	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	0	0	0	0	27.00
28.00	Accumulated depreciation	0	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)	6,773,964	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,018,621	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,018,621	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,436,714	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	918,308	0	0	0	37.00
38.00	Salaries, wages, and fees payable	913,116	0	0	0	38.00
39.00	Payroll taxes payable	91,620	0	0	0	39.00
40.00	Notes and loans payable (short term)	322,278	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	278,786	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,524,108	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,823,274	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)	5,823,274	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,347,382	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,089,332				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)	5,089,332	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,436,714	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet G-1

Date/Time Prepared:
7/15/2019 1:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,900,306		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		189,026				2.00
3.00	Total (sum of line 1 and line 2)		5,089,332		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,089,332		0		11.00
12.00	Deductions (debit adjustments) (specify)	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)		5,089,332		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		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: 14-1324

Period:
From 04/01/2018
To 03/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
7/15/2019 1:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,121,963		3,121,963	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	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)	3,121,963		3,121,963	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)	3,121,963		3,121,963	17.00
18.00	Ancillary services	7,448,643	32,674,755	40,123,398	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	6,449,576	6,449,576	20.00
20.01	RURAL HEALTH CLINIC II	0	231,750	231,750	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	SENIOR CARE CLINIC	0	944,354	944,354	27.00
27.01	MCLEANSBORO CLINIC	0	61,632	61,632	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,570,606	40,362,067	50,932,673	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,715,011		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	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)		23,715,011		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2018
To 03/31/2019

Worksheet G-3

Date/Time Prepared:
7/15/2019 1:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	50,932,673	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,508,198	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,424,475	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,715,011	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,290,536	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	135,747	6.00
7.00	Income from investments	67,722	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	49	10.00
11.00	Rebates and refunds of expenses	84,852	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	36,564	14.00
15.00	Revenue from rental of living quarters	2,995	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	14,137	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	1,137,496	24.00
25.00	Total other income (sum of lines 6-24)	1,479,562	25.00
26.00	Total (line 5 plus line 25)	189,026	26.00
27.00	OTHER EXPENSES (SPECIFY)	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)	189,026	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8506

From 04/01/2018
To 03/31/2019Date/Time Prepared:
7/15/2019 1:15 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	2,095,060	0	2,095,060	-45,863	2,049,197
2.00	Physician Assistant	711,952	0	711,952	-125,299	586,653
3.00	Nurse Practitioner	272,164	0	272,164	0	272,164
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	16,264	0	16,264	0	16,264
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	3,095,440	0	3,095,440	-171,162	2,924,278
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	53,729	53,729	0	53,729
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	53,729	53,729	0	53,729
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,095,440	53,729	3,149,169	-171,162	2,978,007
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	16,716	16,716	-5,123	11,593
30.00	Administrative Costs	1,180,738	807,360	1,988,098	-561,039	1,427,059
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,180,738	824,076	2,004,814	-566,162	1,438,652
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,276,178	877,805	5,153,983	-737,324	4,416,659

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8506

From 04/01/2018
To 03/31/2019Date/Time Prepared:
7/15/2019 1:15 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	2,049,197		1.00
2.00	Physician Assistant	0	586,653		2.00
3.00	Nurse Practitioner	0	272,164		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	16,264		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,924,278		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	53,729		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	53,729		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,978,007		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	-2,995	8,598		29.00
30.00	Administrative Costs	0	1,427,059		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,995	1,435,657		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,995	4,413,664		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8588

From 04/01/2018
To 03/31/2019Date/Time Prepared:
7/15/2019 1:15 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	127,862	0	127,862	-18,220	109,642
3.00	Nurse Practitioner	0	0	0	125,299	125,299
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	127,862	0	127,862	107,079	234,941
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	3,676	3,676	-524	3,152
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	3,676	3,676	-524	3,152
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	127,862	3,676	131,538	106,555	238,093
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	77,731	77,731	-11,077	66,654
30.00	Administrative Costs	67,161	72,564	139,725	-79,135	60,590
31.00	Total Facility Overhead (sum of lines 29 and 30)	67,161	150,295	217,456	-90,212	127,244
32.00	Total facility costs (sum of lines 22, 28 and 31)	195,023	153,971	348,994	16,343	365,337

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8588

From 04/01/2018
To 03/31/2019Date/Time Prepared:
7/15/2019 1:15 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	109,642		2.00
3.00	Nurse Practitioner	0	125,299		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	234,941		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	3,152		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3,152		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	238,093		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	-45,716	20,938		29.00
30.00	Administrative Costs	0	60,590		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-45,716	81,528		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-45,716	319,621		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324

Period:

Worksheet M-2

Component CCN: 14-8506

From 04/01/2018
To 03/31/2019Date/Time Prepared:
7/15/2019 1:15 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	5.53	17,808	4,200	23,226		1.00
2.00	Physician Assistant	2.01	4,798	2,100	4,221		2.00
3.00	Nurse Practitioner	2.34	7,357	2,100	4,914		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.88	29,963		32,361	32,361	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	9.88	29,963			32,361	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)					2,978,007	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,978,007	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,435,657	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,381,835	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,817,492	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,817,492	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,817,492	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,795,499	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324

Period:

Worksheet M-2

Component CCN: 14-8588

From 04/01/2018
To 03/31/2019Date/Time Prepared:
7/15/2019 1:15 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	3,602	0		1.00
2.00	Physician Assistant	0.27	2,412	1,801	486		2.00
3.00	Nurse Practitioner	0.10	854	1,801	180		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.37	3,266		666	3,266	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.37	3,266			3,266	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)					238,093	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					238,093	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					81,528	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					342,560	15.00
16.00	Total overhead (sum of lines 14 and 15)					424,088	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					424,088	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					424,088	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					662,181	20.00

Health Financial Systems		FERRELL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1324	Period: From 04/01/2018 To 03/31/2019	Worksheet M-3	
		Component CCN: 14-8506		Date/Time Prepared: 7/15/2019 1:15 pm	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,795,499	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			372,353	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,423,146	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			32,361	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)			32,361	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			198.48	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		198.48	198.48	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		7,964	2,655	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		1,580,695	526,964	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	2,107,659	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,664,682	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			1,561,256	16.04
16.05	Total program cost (see instructions)		0	1,561,256	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			156,089	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			301,718	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,561,256	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			270,933	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,832,189	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)			1,832,189	26.00
26.01	Sequestration adjustment (see instructions)			36,644	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,588,352	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)			207,193	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: 14-1324 Component CCN: 14-8588	Period: From 04/01/2018 To 03/31/2019	Worksheet M-3 Date/Time Prepared: 7/15/2019 1:15 pm	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			662,181	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			61,203	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			600,978	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,266	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)			3,266	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			184.01	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		184.01	184.01	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)				16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				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.)				16.04
16.05	Total program cost (see instructions)		0	0	16.05
17.00	Primary payer amounts				17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			42,706	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			42,706	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)			42,706	26.00
26.01	Sequestration adjustment (see instructions)			854	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			0	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)			41,852	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2018 To 03/31/2019	Worksheet M-4 Date/Time Prepared: 7/15/2019 1:15 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,924,278	2,924,278	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.006229	0.007239	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		18,215	21,169	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		101,785	22,008	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		120,000	43,177	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,978,007	2,978,007	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,817,492	3,817,492	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.040295	0.014499	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		153,826	55,350	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		273,826	98,527	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		789	917	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		347.05	107.44	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		607	561	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		210,659	60,274	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			372,353	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			270,933	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1324 Component CCN: 14-8588	Period: From 04/01/2018 To 03/31/2019	Worksheet M-4 Date/Time Prepared: 7/15/2019 1:15 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		234,941	234,941	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.014502	0.028788	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,407	6,763	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		8,644	3,192	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		12,051	9,955	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		238,093	238,093	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		424,088	424,088	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.050615	0.041811	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		21,465	17,732	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		33,516	27,687	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		67	133	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		500.24	208.17	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		50	85	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		25,012	17,694	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			61,203	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			42,706	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2018 To 03/31/2019	Worksheet M-5 Date/Time Prepared: 7/15/2019 1:15 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,312,021	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	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		03/28/2019	276,331		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)		276,331		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,588,352		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		207,193		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,795,545		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00