

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

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet S
Parts I-III
Date/Time Prepared:
7/15/2020 9:50 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/15/2020	Time: 9:50 am
	2. ☐ Manually prepared 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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 04/01/2019 and ending 03/31/2020 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) DIRK MORGAN

Officer or Administrator of Provider(s)

CFO

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	328,955	-97,769	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	293,635	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		725,527		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-250,742		0	10.01
200.00	Total	0	622,590	377,016	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-1324		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/15/2020 9:50 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1201 PINE STREET			PO Box:				1.00			
2.00	City: EL DORADO			State: IL		Zip Code: 62930		County: SALINE			
		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 OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		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)						04/01/2019	03/31/2020		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)					N	N			22.03	
23.00	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.										
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	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 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/15/2020 9:50 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/15/2020 9:50 am

	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
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
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
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/15/2020 9:50 am	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
						1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				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:	117,139		0	0	118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/15/2020 9:50 am	
		1.00		2.00			
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	Removed and reserved					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	
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		2.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
		1.00		2.00			
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	
		1.00		2.00		3.00	
		4.00		5.00		6.00	
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		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	SUBPROVIDER	N		N		158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC	N		N		161.00	
		1.00		2.00			
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	
		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	
		1.00		2.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/15/2020 9:50 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1324		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part II Date/Time Prepared: 7/15/2020 9:50 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	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	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/22/2019	Y	05/22/2019		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/15/2020 9:50 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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	09/30/2019	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 04/01/2019
To 03/31/2020Worksheet S-2
Part II
Date/Time Prepared:
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		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 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/15/2020 9:50 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	40,728.00	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	9,150	40,728.00	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	9,150	40,728.00	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 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/15/2020 9:50 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,150	19	1,697		1.00
2.00	HMO and other (see instructions)	0	178			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	960	0	1,032		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	83		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,110	19	2,812		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)	2,110	19	2,812	0.00	125.16
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RHC (CONSOLIDATED)	11,477	0	28,240	0.00	25.00
26.01	RURAL HEALTH CLINIC II	2,475	0	8,079	0.00	20.65
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	5.72
27.00	Total (sum of lines 14-26)				0.00	0.00
28.00	Observation Bed Days		72	594		0.00
29.00	Ambulance Trips	0				151.53
30.00	Employee discount days (see instruction)			0		27.00
31.00	Employee discount days - IRF			0		28.00
32.00	Labor & delivery days (see instructions)	0	0	0		29.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		30.00
33.00	LTCH non-covered days	0				31.00
33.01	LTCH site neutral days and discharges	0				32.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/15/2020 9:50 am

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	315	5	463	1.00
2.00 HMO and other (see instructions)			0	49		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	315	5	463	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 04/01/2019 To 03/31/2020		Worksheet S-8 Date/Time Prepared: 7/15/2020 9:50 am	
				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		from	
				1.00 2.00		3.00 4.00		5.00	
11.00	Facility hours of operations (1) CLINIC			13:00 17:00		07:00 19:00		07:00	
				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	
				1.00		2.00		3.00	
								XIX	
								Total Visits	
				1.00		2.00		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County			SALINE			2.00		
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00 7.00		8.00 9.00		10.00	
Facility hours of operations (1)									
11.00	CLINIC			19:00 07:00		19:00 07:00		19:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1324

Period:

Worksheet S-8

Component CCN: 14-8506

From 04/01/2019
To 03/31/2020Date/Time Prepared:
7/15/2020 9:50 am

RHC I

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-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1324 Component CCN: 14-8588		Period: From 04/01/2019 To 03/31/2020		Worksheet S-8 Date/Time Prepared: 7/15/2020 9:50 am	
				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			CARM		IL 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		Tuesday	
				from to		from to		from	
				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		07:00 11.00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			WHITE				2.00	
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC			19:00 07:00		19:00 07:00		19:00 11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1324 Component CCN: 14-8588		Period: From 04/01/2019 To 03/31/2020		Worksheet S-8 Date/Time Prepared: 7/15/2020 9:50 am	
						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 04/01/2019 To 03/31/2020	Worksheet S-10 Date/Time Prepared: 7/15/2020 9:50 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.544101 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,482,549		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	2,125,178		5.00
6.00	Medicaid charges	9,175,605		6.00
7.00	Medicaid cost (line 1 times line 6)	4,992,456		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)	1,384,729		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)	1,384,729		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	519,624	0	519,624 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	282,728	0	282,728 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	282,728	0	282,728 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,375,898		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	575,352		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	885,158		27.01
28.00	Non-Medicare bad debt expense (see instructions)	490,740		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	576,818		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	859,546		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,244,275		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet A

Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		747,303	747,303	-206,219	541,084	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD		0	0	50,904	50,904	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	390,691	390,691	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	114,897	2,173,284	2,288,181	-369	2,287,812	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	788,557	224,926	1,013,483	296,474	1,309,957	5.01
5.02	00591	OTHER ADMIN AND GENERAL	425,364	2,824,833	3,250,197	-97,555	3,152,642	5.02
6.00	00600	MAINTENANCE & REPAIRS	245,186	312,195	557,381	-222,276	335,105	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	216,962	216,962	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,907	18,907	-11,140	7,767	8.00
9.00	00900	HOUSEKEEPING	268,957	51,844	320,801	-22,642	298,159	9.00
10.00	01000	DIETARY	195,622	150,964	346,586	-133,115	213,471	10.00
11.00	01100	CAFETERIA	0	0	0	118,418	118,418	11.00
13.00	01300	NURSING ADMINISTRATION	338,214	89,338	427,552	-3,317	424,235	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	217,884	32,041	249,925	-455	249,470	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	354,908	354,908	-1,411	353,497	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,575,702	184,256	1,759,958	8,139	1,768,097	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	495,698	242,771	738,469	-172,118	566,351	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	582,945	548,205	1,131,150	-20,044	1,111,106	54.00
60.00	06000	LABORATORY	596,930	777,232	1,374,162	-345,224	1,028,938	60.00
65.00	06500	RESPIRATORY THERAPY	410,354	83,485	493,839	-67,371	426,468	65.00
66.00	06600	PHYSICAL THERAPY	0	723,963	723,963	-3,437	720,526	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	146	-554	-408	817,450	817,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	51,063	51,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	235,879	1,176,949	1,412,828	-6,842	1,405,986	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,802,441	928,827	4,731,268	-348,319	4,382,949	88.00
88.01	08801	RURAL HEALTH CLINIC II	818,404	164,242	982,646	-24,420	958,226	88.01
90.00	09000	CLINIC	81,832	217,166	298,998	-1,289	297,709	90.00
90.01	09001	CLINIC - MCLEANSBORO	500,840	132,053	632,893	-42,371	590,522	90.01
90.02	09002	CLINIC - CHF	0	1,215	1,215	0	1,215	90.02
91.00	09100	EMERGENCY	579,990	1,531,806	2,111,796	-157,257	1,954,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		586,895	586,895	-62,910	523,985	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,275,842	14,279,054	26,554,896	0	26,554,896	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		TOTAL (SUM OF LINES 118 through 199)	12,275,842	14,279,054	26,554,896	0	26,554,896	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet A

Date/Time Prepared:
7/15/2020 9:50 am

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	541,084	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	50,904	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-10,291	380,400	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	944,536	3,232,348	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,309,957	5.01
5.02	00591	OTHER ADMIN AND GENERAL	1,599,541	4,752,183	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	335,105	6.00
7.00	00700	OPERATION OF PLANT	364,205	581,167	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,767	8.00
9.00	00900	HOUSEKEEPING	0	298,159	9.00
10.00	01000	DIETARY	80,262	293,733	10.00
11.00	01100	CAFETERIA	-35,443	82,975	11.00
13.00	01300	NURSING ADMINISTRATION	58,295	482,530	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,011	231,459	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	353,497	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,768,097	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-55	566,296	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,619	1,109,487	54.00
60.00	06000	LABORATORY	-45	1,028,893	60.00
65.00	06500	RESPIRATORY THERAPY	0	426,468	65.00
66.00	06600	PHYSICAL THERAPY	0	720,526	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	817,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	51,063	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-34,262	1,371,724	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	39,801	4,422,750	88.00
88.01	08801	RURAL HEALTH CLINIC II	-20,967	937,259	88.01
90.00	09000	CLINIC	0	297,709	90.00
90.01	09001	CLINIC - MCLEANSBORO	-22,730	567,792	90.01
90.02	09002	CLINIC - CHF	-1,215	0	90.02
91.00	09100	EMERGENCY	0	1,954,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-523,985	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,418,017	28,972,913	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	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)	2,418,017	28,972,913	200.00

RECLASSIFICATIONS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
7/15/2020 9:50 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	69,798	48,620		1.00
	0		69,798	48,620		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	54,077		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,553		2.00
3.00	LABORATORY	60.00	0	1,139		3.00
	0		0	57,769		
	C - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	39,982		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,609		2.00
	0		0	53,591		
	D - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,141		1.00
	0		0	5,141		
	E - RHC BUSINESS OFFICE RECLASS					
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	230,449	71,390		1.00
	0		230,449	71,390		
	F - MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	377,082		1.00
	0		0	377,082		
	G - ADMIN RECRUITING					
1.00	RURAL HEALTH CLINIC	88.00	0	16,667		1.00
	0		0	16,667		
	H - EFM BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,663		1.00
2.00	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	50,904		2.00
3.00		0.00	0	0		3.00
	0		0	122,567		
	I - BILLABLE OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	36,389		1.00
	0		0	36,389		
	K - IMPLANT EXPENSE					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	51,063		1.00
	0		0	51,063		
	L - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	832,124		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
	0		0	832,124		
	M - PLANT OPERATIONS RECLASS					
1.00	OPERATION OF PLANT	7.00	0	216,962		1.00
	0		0	216,962		
	N - RHC RECLASS					
1.00	RURAL HEALTH CLINIC II	88.01	91,576	16,268		1.00
	0		91,576	16,268		
	O - CARMi CLINIC RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	95,475	126		1.00
	0		95,475	126		

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
7/15/2020 9:50 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
P - HOSPITALIST					
1.00 ADULTS & PEDIATRICS	30.00	0	102,751		1.00
TOTALS		0	102,751		
500.00 Grand Total: Increases		487,298	2,008,510		500.00

RECLASSIFICATIONS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
7/15/2020 9:50 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COSTS						
1.00	DIETARY	10.00	69,798	48,620	0		1.00
			69,798	48,620			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	57,769	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
			0	57,769			
	C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.02	0	53,591	13		1.00
2.00		0.00	0	0	13		2.00
			0	53,591			
	D - PROPERTY TAXES						
1.00	INTEREST EXPENSE	113.00	0	5,141	13		1.00
			0	5,141			
	E - RHC BUSINESS OFFICE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	230,449	71,390	0		1.00
			230,449	71,390			
	F - MME DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	377,082	9		1.00
			0	377,082			
	G - ADMIN RECRUITING						
1.00	OTHER ADMIN AND GENERAL	5.02	0	16,667	0		1.00
			0	16,667			
	H - EFM BUILDING RENT						
1.00	RURAL HEALTH CLINIC	88.00	0	50,904	10		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	36,663	10		2.00
3.00	CLINIC - MCLEANSBORO	90.01	0	35,000	0		3.00
			0	122,567			
	I - BILLABLE OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	36,389	0		1.00
			0	36,389			
	K - IMPLANT EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	51,063	0		1.00
			0	51,063			
	L - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	369	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	5,365	0		2.00
3.00	OTHER ADMIN AND GENERAL	5.02	0	27,297	0		3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	5,314	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	11,140	0		5.00
6.00	HOUSEKEEPING	9.00	0	22,642	0		6.00
7.00	DIETARY	10.00	0	14,697	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	3,317	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	455	0		9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,411	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	94,612	0		11.00
12.00	OPERATING ROOM	50.00	0	172,118	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,597	0		13.00
14.00	LABORATORY	60.00	0	346,363	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	30,982	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	3,437	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,842	0		17.00
18.00	CLINIC	90.00	0	1,289	0		18.00
19.00	CLINIC - MCLEANSBORO	90.01	0	7,371	0		19.00
20.00	EMERGENCY	91.00	0	54,506	0		20.00
			0	832,124			
	M - PLANT OPERATIONS RECLASS						
1.00	MAINTENANCE & REPAIRS	6.00	0	216,962	0		1.00
			0	216,962			
	N - RHC RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	91,576	16,268	0		1.00
			91,576	16,268			
	O - CARMICLINIC RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	95,475	126	0		1.00
			95,475	126			
	P - HOSPITALIST						
1.00	EMERGENCY	91.00	0	102,751	0		1.00
	TOTALS		0	102,751			
500.00	Grand Total: Decreases		487,298	2,008,510			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/15/2020 9:50 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	183,412	4,915	0	4,915	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	6,993,359	10,308,555	0	10,308,555	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	4,182,364	189,393	0	189,393	0	6.00	
7.00	HIT designated Assets	1,506,186	75,271	0	75,271	0	7.00	
8.00	Subtotal (sum of lines 1-7)	12,865,321	10,578,134	0	10,578,134	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	12,865,321	10,578,134	0	10,578,134	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	188,327	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	17,301,914	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	4,371,757	0				6.00	
7.00	HIT designated Assets	1,581,457	0				7.00	
8.00	Subtotal (sum of lines 1-7)	23,443,455	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	23,443,455	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	747,303	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)	747,303	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	747,303				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	747,303				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	17,490,241	0	17,490,241	0.746061	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	5,953,214	0	5,953,214	0.253939	0	2.00
3.00	Total (sum of lines 1-2)	23,443,455	0	23,443,455	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	370,221	71,663	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	50,904	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	366,791	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	737,012	122,567	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	54,077	0	45,123	0	541,084	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	50,904	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,609	0	380,400	2.00
3.00	Total (sum of lines 1-2)	54,077	0	58,732	0	972,388	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8

Date/Time Prepared:
7/15/2020 9:50 am

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 #		
				3.00	4.00		
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	-19,367	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	-50,752	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	-1,574	OTHER ADMIN AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,277	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	-24,449			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	3,529,667			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-35,443	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-21,430	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	-18,011	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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - EFM BLD			0CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8

Date/Time Prepared:
7/15/2020 9:50 am

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 #		
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	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-10,291	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LOBBYING DUES	A	-9,823	OTHER ADMIN AND GENERAL	5.02	0	33.00
34.00	PROVIDER TAX OFFSET	A	-504,618	INTEREST EXPENSE	113.00	0	34.00
35.00	CARMi CLINIC MISC REVENUE	B	-58,445	RURAL HEALTH CLINIC II	88.01	0	35.00
35.01	A & G PURCHASE DISCOUNTS	B	-557	OTHER ADMIN AND GENERAL	5.02	0	35.01
35.02	340B OFFSET	A	-232,043	DRUGS CHARGED TO PATIENTS	73.00	0	35.02
35.03	CLINIC CHF OFFSET	A	-1,215	CLINIC - CHF	90.02	0	35.03
35.04	NON ALLOWABLE ADVERTISING	A	-108,702	OTHER ADMIN AND GENERAL	5.02	0	35.04
35.05	NON ALLOWABLE ADVERTISING - HUMAN RE	A	-5,553	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.05
35.06	NON ALLOWABLE ADVERTISING - DIETARY	A	-100	DIETARY	10.00	0	35.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		2,418,017				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 04/01/2019
To 03/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/15/2020 9:50 am

	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	950,089	0	1.00
2.00	5.02	OTHER ADMIN AND GENERAL	DHS - A&G	1,654,846	120,027	2.00
3.00	7.00	OPERATION OF PLANT	DHS - OPERATION PLANT	364,205	0	3.00
4.00	10.00	DIETARY	DHS - DIETARY	80,362	0	4.00
4.01	13.00	NURSING ADMINISTRATION	DHS - NURSING ADMIN	58,295	0	4.01
4.02	73.00	DRUGS CHARGED TO PATIENTS	DHS - PHARMACY	248,533	0	4.02
4.03	5.02	OTHER ADMIN AND GENERAL	DHS - CASE MANAGEMENT	133,876	0	4.03
4.04	88.00	RURAL HEALTH CLINIC	DHS - EL DORADO	15,814	0	4.04
4.05	88.01	RURAL HEALTH CLINIC II	DHS - CARM	37,478	0	4.05
4.06	88.00	RURAL HEALTH CLINIC	DHS - FERRELL FAMILY	45,417	0	4.06
4.07	5.02	OTHER ADMIN AND GENERAL	DHS - RHC BUSINESS OFFICE	60,779	0	4.07
4.08	5.01	CASHIERING/ACCOUNTS RECEIVAB	DEACONESS HOSPITAL - EPIC US	44,860	44,860	4.08
4.09	5.02	OTHER ADMIN AND GENERAL	DEACONESS HOSPITAL - SUPPLIE	3,270	3,270	4.09
4.10	16.00	MEDICAL RECORDS & LIBRARY	DEACONESS HOSPITAL - SUPPLIE	90	90	4.10
4.11	30.00	ADULTS & PEDIATRICS	DEACONESS HOSPITAL - SUPPLIE	2,127	2,127	4.11
4.12	50.00	OPERATING ROOM	DEACONESS HOSPITAL - SUPPLIE	635	635	4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC	DEACONESS HOSPITAL - SUPPLIE	45	45	4.13
4.14	88.00	RURAL HEALTH CLINIC	DEACONESS HOSPITAL - SUPPLIE	745	745	4.14
4.15	194.00	MARKETING	DEACONESS HOSPITAL - SUPPLIE	3,251	3,251	4.15
4.16	50.00	OPERATING ROOM	DRHS IL - PAIN MGT COVERAGE	97,618	97,618	4.16
4.17	91.00	EMERGENCY	DRHS IL - ER COVERAGE	749,250	749,250	4.17
4.18	5.02	OTHER ADMIN AND GENERAL	DRHS IL - C SUITE SALARY/BEN	393,410	393,410	4.18
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,944,995	1,415,328	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 04/01/2019
To 03/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/15/2020 9:50 am

	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	950,089	0		1.00
2.00	1,534,819	0		2.00
3.00	364,205	0		3.00
4.00	80,362	0		4.00
4.01	58,295	0		4.01
4.02	248,533	0		4.02
4.03	133,876	0		4.03
4.04	15,814	0		4.04
4.05	37,478	0		4.05
4.06	45,417	0		4.06
4.07	60,779	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
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
5.00	3,529,667			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 04/01/2019
To 03/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/15/2020 9:50 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	102,751	0	102,751	0	0	1.00
2.00	50.00	OPERATING ROOM	55	55	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,619	1,619	0	0	0	3.00
4.00	60.00	LABORATORY	45	45	0	0	0	4.00
5.00	91.00	EMERGENCY	1,312,515	0	1,312,515	0	0	5.00
6.00	90.01	CLINIC - MCLEANSBORO	22,730	22,730	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			1,439,715	24,449	1,415,266		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	90.01	CLINIC - MCLEANSBORO	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	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	50.00	OPERATING ROOM	0	0	0	55		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,619		3.00
4.00	60.00	LABORATORY	0	0	0	45		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	90.01	CLINIC - MCLEANSBORO	0	0	0	22,730		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	24,449		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2020 9:50 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	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	142.00	1,540.00	3,669.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	84.95	84.95	63.71	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)	42.48	42.48	31.86			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)					12,063	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					130,823	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					233,752	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					376,638	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)					376,638	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)					376,638	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 04/01/2019
To 03/31/2020Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
7/15/2020 9:50 am

					Physical Therapy	Cost				
						1.00				
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00			
					Therapists	Assistants	Aides	Trainees	Total	
					1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION										
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)				0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)				0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)				0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT										
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)				0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)				0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE										
52.00	Adjusted hourly salary equivalency amount (see instructions)				84.95	63.71	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)								376,638	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)								5,961	61.00
62.00	Supplies (see instructions)								4,647	62.00
63.00	Total allowance (sum of lines 57-62)								387,246	63.00
64.00	Total cost of outside supplier services (from your records)								302,898	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 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2020 9:50 am	
				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	63.00	1,061.00	1,253.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	80.50	80.50	60.38	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.25	40.25	30.19			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)					5,072	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					85,411	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					75,656	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					166,139	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)					166,139	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)					166,139	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 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2020 9:50 am		
				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)	80.50	60.38	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)						166,139	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)						166,139	63.00
64.00	Total cost of outside supplier services (from your records)						134,557	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 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2020 9:50 am		
				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	9.00	337.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	77.36	77.36	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.68	38.68	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)						696	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						26,070	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)						26,766	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)						26,766	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)						77.36	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						60,341	22.00
23.00	Total salary equivalency (see instructions)						60,341	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 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/15/2020 9:50 am		
				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	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	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)	77.36	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)						60,341	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)						60,341	63.00
64.00	Total cost of outside supplier services (from your records)						19,596	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 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
7/15/2020 9:50 am

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	541,084	541,084			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	50,904	0	50,904		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	380,400		380,400		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,232,348	3,261	0	1,922	3,237,531
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,309,957	292	0	172	84,491
5.02	00591	OTHER ADMIN AND GENERAL	4,752,183	77,361	0	45,596	621,107
6.00	00600	MAINTENANCE & REPAIRS	335,105	111,185	0	65,532	81,481
7.00	00700	OPERATION OF PLANT	581,167	0	565	682	0
8.00	00800	LAUNDRY & LINEN SERVICE	7,767	10,678	0	6,293	0
9.00	00900	HOUSEKEEPING	298,159	3,573	128	2,260	202,950
10.00	01000	DIETARY	293,733	19,655	0	11,584	74,601
11.00	01100	CAFETERIA	82,975	0	0	0	41,493
13.00	01300	NURSING ADMINISTRATION	482,530	1,087	0	641	17,844
16.00	01600	MEDICAL RECORDS & LIBRARY	231,459	17,682	0	10,422	104,270
19.00	01900	NONPHYSICIAN ANESTHETISTS	353,497	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,768,097	89,498	0	52,750	491,682
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	566,296	35,052	0	20,660	129,424
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,109,487	28,129	0	16,579	154,578
60.00	06000	LABORATORY	1,028,893	12,751	0	7,515	269,597
65.00	06500	RESPIRATORY THERAPY	426,468	13,395	0	7,895	117,814
66.00	06600	PHYSICAL THERAPY	720,526	12,338	0	7,272	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	817,042	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,063	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,371,724	6,914	0	4,075	42,353
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,422,750	81,487	50,211	108,680	443,954
88.01	08801	RURAL HEALTH CLINIC II	937,259	0	0	0	122,974
90.00	09000	CLINIC	297,709	0	0	0	36,333
90.01	09001	CLINIC - MCLEANSBORO	567,792	0	0	0	58,907
90.02	09002	CLINIC - CHF	0	0	0	0	0
91.00	09100	EMERGENCY	1,954,539	16,746	0	9,870	141,678
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)	28,972,913	541,084	50,904	380,400	3,237,531
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)	28,972,913	541,084	50,904	380,400	3,237,531

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description			CASHIERING/AC COUNTS 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	1,394,912					5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	5,496,247	5,496,247			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	593,303	138,901	732,204		6.00
7.00	00700	OPERATION OF PLANT	0	582,414	136,352	1,869	720,635	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,738	5,792	17,247	17,018	8.00
9.00	00900	HOUSEKEEPING	0	507,070	118,713	6,193	6,111	9.00
10.00	01000	DIETARY	0	399,573	93,546	31,747	31,326	10.00
11.00	01100	CAFETERIA	0	124,468	29,140	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	502,102	117,550	1,756	1,732	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	363,833	85,179	28,561	28,182	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	353,497	82,759	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	95,579	2,497,606	584,727	144,562	142,642	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	71,329	822,761	192,621	56,618	55,867	50.00
53.00	05300	ANESTHESIOLOGY	37,806	37,806	8,851	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,753	1,597,526	374,005	45,435	44,831	54.00
60.00	06000	LABORATORY	273,967	1,592,723	372,880	20,596	20,322	60.00
65.00	06500	RESPIRATORY THERAPY	36,644	602,216	140,988	21,636	21,349	65.00
66.00	06600	PHYSICAL THERAPY	77,464	817,600	191,412	19,929	19,665	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,729	854,771	200,115	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,871	55,934	13,095	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,458	1,549,524	362,767	11,168	11,019	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	181,009	5,288,091	1,238,027	297,838	293,881	88.00
88.01	08801	RURAL HEALTH CLINIC II	33,163	1,093,396	255,980	0	0	88.01
90.00	09000	CLINIC	29,545	363,587	85,121	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	17,513	644,212	150,820	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	85,082	2,207,915	516,906	27,049	26,690	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)	1,394,912	28,972,913	5,496,247	732,204	720,635	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	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,394,912	28,972,913	5,496,247	732,204	720,635	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	
			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	00500	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	64,795					8.00
9.00	00900	HOUSEKEEPING	12,205	650,292				9.00
10.00	01000	DIETARY	352	29,205	585,749			10.00
11.00	01100	CAFETERIA	0	0	0	153,608		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,615	0	1,398	626,153	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,274	0	8,223	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,177	132,986	585,749	38,738	349,674	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,263	52,085	0	10,192	91,991	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,554	41,797	0	12,181	0	54.00
60.00	06000	LABORATORY	18	18,947	0	21,246	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	19,904	0	9,280	83,772	65.00
66.00	06600	PHYSICAL THERAPY	2,223	18,334	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	10,273	0	3,345	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	423	273,988	0	34,982	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	2,865	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	580	24,884	0	11,158	100,716	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)	64,795	650,292	585,749	153,608	626,153	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	64,795	650,292	585,749	153,608	626,153	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
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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	540,252					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	436,256				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	194,250	0	4,711,111	0	4,711,111	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,288,398	0	1,288,398	50.00
53.00	05300	ANESTHESIOLOGY	0	436,256	482,913	0	482,913	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,140	0	2,130,469	0	2,130,469	54.00
60.00	06000	LABORATORY	12,140	0	2,058,872	0	2,058,872	60.00
65.00	06500	RESPIRATORY THERAPY	12,140	0	911,285	0	911,285	65.00
66.00	06600	PHYSICAL THERAPY	12,140	0	1,081,303	0	1,081,303	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,054,886	0	1,054,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	69,029	0	69,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,948,096	0	1,948,096	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	7,427,230	0	7,427,230	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,349,376	0	1,349,376	88.01
90.00	09000	CLINIC	182,107	0	633,680	0	633,680	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	795,032	0	795,032	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	115,335	0	3,031,233	0	3,031,233	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)	540,252	436,256	28,972,913	0	28,972,913	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	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)	540,252	436,256	28,972,913	0	28,972,913	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				BLDG & FIXT	BLDG & FIXT - EFM BLD	MVBLE EQUIP		
				1.00	1.01	2.00		
	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	0	3,261	0	1,922	5,183	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	292	0	172	464	5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	77,361	0	45,596	122,957	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	111,185	0	65,532	176,717	6.00
7.00	00700	OPERATION OF PLANT	0	0	565	682	1,247	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,678	0	6,293	16,971	8.00
9.00	00900	HOUSEKEEPING	0	3,573	128	2,260	5,961	9.00
10.00	01000	DIETARY	0	19,655	0	11,584	31,239	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,087	0	641	1,728	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,682	0	10,422	28,104	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	89,498	0	52,750	142,248	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	35,052	0	20,660	55,712	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,129	0	16,579	44,708	54.00
60.00	06000	LABORATORY	0	12,751	0	7,515	20,266	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,395	0	7,895	21,290	65.00
66.00	06600	PHYSICAL THERAPY	0	12,338	0	7,272	19,610	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	6,914	0	4,075	10,989	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	81,487	50,211	108,680	240,378	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	16,746	0	9,870	26,616	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)	0	541,084	50,904	380,400	972,388	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		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	541,084	50,904	380,400	972,388	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/AC COUNTS 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	5,183					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	135	599				5.01
5.02	00591	OTHER ADMIN AND GENERAL	995	0	123,952			5.02
6.00	00600	MAINTENANCE & REPAIRS	130	0	3,133	179,980		6.00
7.00	00700	OPERATION OF PLANT	0	0	3,075	460	4,782	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	131	4,239	113	8.00
9.00	00900	HOUSEKEEPING	325	0	2,677	1,522	41	9.00
10.00	01000	DIETARY	119	0	2,110	7,804	208	10.00
11.00	01100	CAFETERIA	66	0	657	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	29	0	2,651	432	11	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	167	0	1,921	7,021	187	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,866	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	787	40	13,187	35,534	947	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	207	30	4,344	13,917	371	50.00
53.00	05300	ANESTHESIOLOGY	0	16	200	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247	135	8,435	11,168	297	54.00
60.00	06000	LABORATORY	432	115	8,410	5,063	135	60.00
65.00	06500	RESPIRATORY THERAPY	189	15	3,180	5,318	142	65.00
66.00	06600	PHYSICAL THERAPY	0	33	4,317	4,899	130	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16	4,513	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2	295	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68	52	8,181	2,745	73	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	711	76	27,917	73,209	1,950	88.00
88.01	08801	RURAL HEALTH CLINIC II	197	14	5,773	0	0	88.01
90.00	09000	CLINIC	58	12	1,920	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	94	7	3,401	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	227	36	11,658	6,649	177	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)	5,183	599	123,952	179,980	4,782	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,183	599	123,952	179,980	4,782	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	
			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	00500	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	21,454					8.00
9.00	00900	HOUSEKEEPING	4,041	14,567				9.00
10.00	01000	DIETARY	117	654	42,251			10.00
11.00	01100	CAFETERIA	0	0	0	723		11.00
13.00	01300	NURSING ADMINISTRATION	0	36	0	7	4,894	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	589	0	39	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,302	2,979	42,251	181	2,733	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,074	1,167	0	48	719	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	846	936	0	57	0	54.00
60.00	06000	LABORATORY	6	424	0	100	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	446	0	44	655	65.00
66.00	06600	PHYSICAL THERAPY	736	411	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	230	0	16	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	140	6,138	0	165	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	13	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	192	557	0	53	787	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)	21,454	14,567	42,251	723	4,894	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,454	14,567	42,251	723	4,894	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
7/15/2020 9:50 am

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	38,028					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,866				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,672		267,861	0	267,861	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		78,589	0	78,589	50.00
53.00	05300	ANESTHESIOLOGY	0		216	0	216	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	855		67,684	0	67,684	54.00
60.00	06000	LABORATORY	855		35,806	0	35,806	60.00
65.00	06500	RESPIRATORY THERAPY	855		32,134	0	32,134	65.00
66.00	06600	PHYSICAL THERAPY	855		30,991	0	30,991	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		4,529	0	4,529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		297	0	297	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		22,354	0	22,354	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		350,684	0	350,684	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		5,984	0	5,984	88.01
90.00	09000	CLINIC	12,818		14,821	0	14,821	90.00
90.01	09001	CLINIC - MCLEANSBORO	0		3,502	0	3,502	90.01
90.02	09002	CLINIC - CHF	0		0	0	0	90.02
91.00	09100	EMERGENCY	8,118		55,070	0	55,070	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)	38,028	0	970,522	0	970,522	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		1,866	1,866	0	1,866	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,028	1,866	972,388	0	972,388	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (FTE'S)	CASHIERING/AC COUNTS 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	53,765				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	10,366			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			64,131		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	324	0	324	15,059	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	29	0	29	393	53,249,104
5.02	00591	OTHER ADMIN AND GENERAL	7,687	0	7,687	2,889	0
6.00	00600	MAINTENANCE & REPAIRS	11,048	0	11,048	379	0
7.00	00700	OPERATION OF PLANT	0	115	115	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	1,061	0	1,061	0	0
9.00	00900	HOUSEKEEPING	355	26	381	944	0
10.00	01000	DIETARY	1,953	0	1,953	347	0
11.00	01100	CAFETERIA	0	0	0	193	0
13.00	01300	NURSING ADMINISTRATION	108	0	108	83	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,757	0	1,757	485	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	2,287	3,648,622
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,483	0	3,483	602	2,722,911
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,443,216
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,795	0	2,795	719	11,022,836
60.00	06000	LABORATORY	1,267	0	1,267	1,254	10,458,335
65.00	06500	RESPIRATORY THERAPY	1,331	0	1,331	548	1,398,822
66.00	06600	PHYSICAL THERAPY	1,226	0	1,226	0	2,957,085
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,440,265
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	185,930
73.00	07300	DRUGS CHARGED TO PATIENTS	687	0	687	197	4,751,040
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,097	10,225	18,322	2,065	6,909,789
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	572	1,265,962
90.00	09000	CLINIC	0	0	0	169	1,127,834
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	274	668,556
90.02	09002	CLINIC - CHF	0	0	0	0	0
91.00	09100	EMERGENCY	1,664	0	1,664	659	3,247,901
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)	53,765	10,366	64,131	15,059	53,249,104
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					
202.00		Cost to be allocated (per Wkst. B, Part I)	541,084	50,904	380,400	3,237,531	1,394,912
203.00		Unit cost multiplier (Wkst. B, Part I)	10.063871	4.910669	5.931609	214.989774	0.026196
204.00		Cost to be allocated (per Wkst. B, Part II)				5,183	599
205.00		Unit cost multiplier (Wkst. B, Part II)				0.344180	0.000011
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 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
7/15/2020 9:50 am

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	-5,496,247	23,476,666			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	593,303	45,043		6.00
7.00	00700	OPERATION OF PLANT	0	582,414	115	44,928	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,738	1,061	187,354	8.00
9.00	00900	HOUSEKEEPING	0	507,070	381	35,290	9.00
10.00	01000	DIETARY	0	399,573	1,953	1,019	10.00
11.00	01100	CAFETERIA	0	124,468	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	502,102	108	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	363,833	1,757	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	353,497	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,497,606	8,893	8,893	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	822,761	3,483	18,109	50.00
53.00	05300	ANESTHESIOLOGY	0	37,806	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,597,526	2,795	7,384	54.00
60.00	06000	LABORATORY	0	1,592,723	1,267	52	60.00
65.00	06500	RESPIRATORY THERAPY	0	602,216	1,331	0	65.00
66.00	06600	PHYSICAL THERAPY	0	817,600	1,226	6,429	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	854,771	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	55,934	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,549,524	687	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,288,091	18,322	1,222	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,093,396	0	0	88.01
90.00	09000	CLINIC	0	363,587	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	644,212	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	2,207,915	1,664	1,678	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)	-5,496,247	23,476,666	45,043	44,928	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					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		5,496,247	732,204	64,795	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.234115	16.255667	0.345843	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		123,952	179,980	21,454	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005280	3.995737	0.114510	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 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			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	43,486					9.00
10.00	01000	DIETARY	1,953	1,697				10.00
11.00	01100	CAFETERIA	0	0	188,621			11.00
13.00	01300	NURSING ADMINISTRATION	108	0	1,717	85,179		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,757	0	10,097	0	2,670	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	1,697	47,568	47,568	960	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,483	0	12,515	12,514	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,795	0	14,958	0	60	54.00
60.00	06000	LABORATORY	1,267	0	26,089	0	60	60.00
65.00	06500	RESPIRATORY THERAPY	1,331	0	11,395	11,396	60	65.00
66.00	06600	PHYSICAL THERAPY	1,226	0	0	0	60	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	687	0	4,107	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	18,322	0	42,956	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	3,518	0	900	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	1,664	0	13,701	13,701	570	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)	43,486	1,697	188,621	85,179	2,670	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)	650,292	585,749	153,608	626,153	540,252	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.954054	345.167354	0.814374	7.351025	202.341573	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,567	42,251	723	4,894	38,028	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.334981	24.897466	0.003833	0.057455	14.242697	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 04/01/2019
To 03/31/2020

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
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 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
7/15/2020 9:50 am

				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	4,711,111		4,711,111	0	0	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,288,398		1,288,398	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	482,913		482,913	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,130,469		2,130,469	0	0	54.00	
60.00	06000	LABORATORY	2,058,872		2,058,872	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	911,285	0	911,285	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,081,303	0	1,081,303	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,054,886		1,054,886	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,029		69,029	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,948,096		1,948,096	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,427,230		7,427,230	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	1,349,376		1,349,376	0	0	88.01	
90.00	09000	CLINIC	633,680		633,680	0	0	90.00	
90.01	09001	CLINIC - MCLEANSBORO	795,032		795,032	0	0	90.01	
90.02	09002	CLINIC - CHF	0		0	0	0	90.02	
91.00	09100	EMERGENCY	3,031,233		3,031,233	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	839,797		839,797		0	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	29,812,710	0	29,812,710	0	0	200.00	
201.00		Less Observation Beds	839,797		839,797			201.00	
202.00		Total (see instructions)	28,972,913	0	28,972,913	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
7/15/2020 9:50 am

			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	2,863,521		2,863,521			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	657,482	2,065,429	2,722,911	0.473169	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	33,797	1,409,419	1,443,216	0.334609	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	442,765	10,580,071	11,022,836	0.193278	0.000000	54.00
60.00	06000	LABORATORY	876,357	9,581,978	10,458,335	0.196864	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	436,837	961,985	1,398,822	0.651466	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,067,830	1,889,255	2,957,085	0.365665	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	611,240	829,025	1,440,265	0.732425	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,696	167,234	185,930	0.371263	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,531,744	3,219,296	4,751,040	0.410036	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,909,789	6,909,789			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,265,962	1,265,962			88.01
90.00	09000	CLINIC	0	1,127,834	1,127,834	0.561856	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	668,556	668,556	1.189178	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	98,236	3,149,665	3,247,901	0.933290	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	23,312	761,789	785,101	1.069667	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,661,817	44,587,287	53,249,104			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,661,817	44,587,287	53,249,104			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
7/15/2020 9:50 am

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
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
7/15/2020 9:50 am

				Title XIX		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	4,711,111		4,711,111	0	4,711,111	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,288,398		1,288,398	0	1,288,398	50.00	
53.00	05300	ANESTHESIOLOGY	482,913		482,913	0	482,913	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,130,469		2,130,469	0	2,130,469	54.00	
60.00	06000	LABORATORY	2,058,872		2,058,872	0	2,058,872	60.00	
65.00	06500	RESPIRATORY THERAPY	911,285	0	911,285	0	911,285	65.00	
66.00	06600	PHYSICAL THERAPY	1,081,303	0	1,081,303	0	1,081,303	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,054,886		1,054,886	0	1,054,886	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,029		69,029	0	69,029	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,948,096		1,948,096	0	1,948,096	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,427,230		7,427,230	0	7,427,230	88.00	
88.01	08801	RURAL HEALTH CLINIC II	1,349,376		1,349,376	0	1,349,376	88.01	
90.00	09000	CLINIC	633,680		633,680	0	633,680	90.00	
90.01	09001	CLINIC - MCLEANSBORO	795,032		795,032	0	795,032	90.01	
90.02	09002	CLINIC - CHF	0		0	0	0	90.02	
91.00	09100	EMERGENCY	3,031,233		3,031,233	0	3,031,233	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	839,797		839,797		839,797	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	29,812,710	0	29,812,710	0	29,812,710	200.00	
201.00		Less Observation Beds	839,797		839,797		839,797	201.00	
202.00		Total (see instructions)	28,972,913	0	28,972,913	0	28,972,913	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
7/15/2020 9:50 am

			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	2,863,521		2,863,521		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	657,482	2,065,429	2,722,911	0.473169	0.000000
53.00	05300	ANESTHESIOLOGY	33,797	1,409,419	1,443,216	0.334609	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	442,765	10,580,071	11,022,836	0.193278	0.000000
60.00	06000	LABORATORY	876,357	9,581,978	10,458,335	0.196864	0.000000
65.00	06500	RESPIRATORY THERAPY	436,837	961,985	1,398,822	0.651466	0.000000
66.00	06600	PHYSICAL THERAPY	1,067,830	1,889,255	2,957,085	0.365665	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	611,240	829,025	1,440,265	0.732425	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,696	167,234	185,930	0.371263	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,531,744	3,219,296	4,751,040	0.410036	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,909,789	6,909,789	1.074885	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	1,265,962	1,265,962	1.065890	0.000000
90.00	09000	CLINIC	0	1,127,834	1,127,834	0.561856	0.000000
90.01	09001	CLINIC - MCLEANSBORO	0	668,556	668,556	1.189178	0.000000
90.02	09002	CLINIC - CHF	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	98,236	3,149,665	3,247,901	0.933290	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	23,312	761,789	785,101	1.069667	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	8,661,817	44,587,287	53,249,104		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,661,817	44,587,287	53,249,104		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
7/15/2020 9:50 am

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
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 04/01/2019 To 03/31/2020		Worksheet D Part II Date/Time Prepared: 7/15/2020 9:50 am	
Cost Center Description				Title XVIII		Hospital		Cost	
				Capital Related Cost (from Wkst. C, 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		78,589	2,722,911	0.028862	58,795	1,697	50.00
53.00	05300	ANESTHESIOLOGY		216	1,443,216	0.000150	20,640	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		67,684	11,022,836	0.006140	201,725	1,239	54.00
60.00	06000	LABORATORY		35,806	10,458,335	0.003424	449,743	1,540	60.00
65.00	06500	RESPIRATORY THERAPY		32,134	1,398,822	0.022972	200,686	4,610	65.00
66.00	06600	PHYSICAL THERAPY		30,991	2,957,085	0.010480	139,312	1,460	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		4,529	1,440,265	0.003145	381,265	1,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		297	185,930	0.001597	16,670	27	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		22,354	4,751,040	0.004705	766,817	3,608	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		350,684	6,909,789	0.050752	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		5,984	1,265,962	0.004727	0	0	88.01
90.00	09000	CLINIC		14,821	1,127,834	0.013141	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO		3,502	668,556	0.005238	0	0	90.01
90.02	09002	CLINIC - CHF		0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY		55,070	3,247,901	0.016956	9,726	165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		47,748	785,101	0.060818	0	0	92.00
200.00		Total (lines 50 through 199)		750,409	50,385,583		2,245,379	15,548	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/15/2020 9:50 am

			Title XVIII		Hospital		Cost
Cost Center Description			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
53.00	05300	ANESTHESIOLOGY	436,256	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	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	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	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	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
200.00		Total (lines 50 through 199)	436,256	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1324		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 7/15/2020 9:50 am	
				Title XVIII		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	2,722,911	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	436,256	0	1,443,216	0.302280	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	11,022,836	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	10,458,335	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,398,822	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,957,085	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,440,265	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	185,930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,751,040	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	6,909,789	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,265,962	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0	1,127,834	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	668,556	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	0	3,247,901	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	785,101	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	436,256	0	50,385,583		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/15/2020 9:50 am

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	58,795	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	20,640	6,239	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	201,725	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	449,743	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	200,686	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	139,312	0	0	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	381,265	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	16,670	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	766,817	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	9,726	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)		2,245,379	6,239	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
7/15/2020 9:50 am

			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	0.473169	0	1,016,063	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.334609	0	528,914	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193278	0	4,371,414	0	0	54.00
60.00	06000	LABORATORY	0.196864	0	4,801,450	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.651466	0	484,544	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.365665	0	699,511	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.732425	0	305,912	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371263	0	161,521	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.410036	0	1,802,595	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	0.561856	0	1,050,163	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	1.189178	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.933290	0	1,180,231	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.069667	0	464,614	0	0	92.00
200.00		Subtotal (see instructions)		0	16,866,932	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	16,866,932	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
7/15/2020 9:50 am

			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	480,770	0		50.00
53.00	05300	ANESTHESIOLOGY	176,979	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	844,898	0		54.00
60.00	06000	LABORATORY	945,233	0		60.00
65.00	06500	RESPIRATORY THERAPY	315,664	0		65.00
66.00	06600	PHYSICAL THERAPY	255,787	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	224,058	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,967	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	739,129	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	590,040	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	1,101,498	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	496,982	0		92.00
200.00		Subtotal (see instructions)	6,231,005	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,231,005	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1324 Component CCN: 14-Z324		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 7/15/2020 9:50 am	
Cost Center Description				Title XVIII		Swing Beds - SNF		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	436,256	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	436,256	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324
Component CCN: 14-Z324

Period:
From 04/01/2019
To 03/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,722,911	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	436,256	0	1,443,216	0.302280	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,022,836	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,458,335	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,398,822	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,957,085	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,440,265	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	185,930	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,751,040	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,909,789	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,265,962	0.000000	88.01
90.00	09000	CLINIC	0	0	0	1,127,834	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	668,556	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	3,247,901	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	785,101	0.000000	92.00
200.00		Total (lines 50 through 199)	0	436,256	0	50,385,583		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324

Period:

Worksheet D

Component CCN: 14-Z324

From 04/01/2019
To 03/31/2020

Part IV
Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description			Title XVIII		Swing Beds - SNF		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	11,696	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	14,041	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	138,448	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	85,786	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	730,664	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	127,664	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	387,494	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	258	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)		1,496,051	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1324

Period:

Worksheet D

Component CCN:14-Z324

From 04/01/2019
To 03/31/2020Part V
Date/Time Prepared:
7/15/2020 9:50 am

			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	0.473169	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.334609	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193278	0	0	0	0	54.00
60.00	06000	LABORATORY	0.196864	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.651466	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.365665	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.732425	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371263	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.410036	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	0.561856	0	0	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	1.189178	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.933290	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.069667	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 04/01/2019
To 03/31/2020Part V
Date/Time Prepared:
7/15/2020 9:50 am

			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
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 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
7/15/2020 9:50 am

			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	0.473169	0	96,292	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.334609	0	13,529	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193278	0	286,917	0	0	54.00
60.00	06000	LABORATORY	0.196864	0	116,755	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.651466	0	24,882	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.365665	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.732425	0	23,630	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371263	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.410036	0	36,922	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1.074885				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.065890				0	88.01
90.00	09000	CLINIC	0.561856	0	0	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	1.189178	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.933290	0	118,999	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.069667	0	11,953	0	0	92.00
200.00		Subtotal (see instructions)		0	729,879	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	729,879	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
7/15/2020 9:50 am

				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	45,562	0		50.00
53.00	05300	ANESTHESIOLOGY	4,527	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,455	0		54.00
60.00	06000	LABORATORY	22,985	0		60.00
65.00	06500	RESPIRATORY THERAPY	16,210	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,307	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,139	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	111,061	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	12,786	0		92.00
200.00		Subtotal (see instructions)	301,032	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	301,032	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2019 To 03/31/2020	Worksheet D-1 Date/Time Prepared: 7/15/2020 9:50 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,406	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,291	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)			1,697	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)			1,032	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			83	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,150	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)			960	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			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,711,111	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)			13,047	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			1,472,089	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,239,022	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,239,022	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)			1,413.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,625,870	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)			1,625,870	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					952,872	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,578,742	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)					1,357,248	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,357,248	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)					594	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,413.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					839,797	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324		Period: From 04/01/2019 To 03/31/2020		Worksheet D-1 Date/Time Prepared: 7/15/2020 9:50 am	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	267,861	4,711,111	0.056857	839,797	47,748	90.00
91.00	Nursing School cost	0	4,711,111	0.000000	839,797	0	91.00
92.00	Allied health cost	0	4,711,111	0.000000	839,797	0	92.00
93.00	All other Medical Education	0	4,711,111	0.000000	839,797	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2019 To 03/31/2020	Worksheet D-1 Date/Time Prepared: 7/15/2020 9:50 am	
		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)			3,406	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,291	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)			1,697	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)			1,032	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			83	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			19	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			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,711,111	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)			13,047	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			1,472,089	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,239,022	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,239,022	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)			1,413.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			26,862	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)			26,862	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					21,053	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					47,915	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)					594	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,413.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					839,797	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324		Period: From 04/01/2019 To 03/31/2020		Worksheet D-1 Date/Time Prepared: 7/15/2020 9:50 am	
		Title XIX		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	267,861	4,711,111	0.056857	839,797	47,748	90.00
91.00	Nursing School cost	0	4,711,111	0.000000	839,797	0	91.00
92.00	Allied health cost	0	4,711,111	0.000000	839,797	0	92.00
93.00	All other Medical Education	0	4,711,111	0.000000	839,797	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 7/15/2020 9:50 am	
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		1,602,632		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.473169	58,795	27,820	50.00
53.00	05300 ANESTHESIOLOGY	0.334609	20,640	6,906	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193278	201,725	38,989	54.00
60.00	06000 LABORATORY	0.196864	449,743	88,538	60.00
65.00	06500 RESPIRATORY THERAPY	0.651466	200,686	130,740	65.00
66.00	06600 PHYSICAL THERAPY	0.365665	139,312	50,942	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.732425	381,265	279,248	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.371263	16,670	6,189	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.410036	766,817	314,423	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	0.561856	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	1.189178	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.933290	9,726	9,077	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.069667	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,245,379	952,872	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)		2,245,379		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 7/15/2020 9:50 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.473169	11,696	5,534	50.00
53.00	05300 ANESTHESIOLOGY	0.334609	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193278	14,041	2,714	54.00
60.00	06000 LABORATORY	0.196864	138,448	27,255	60.00
65.00	06500 RESPIRATORY THERAPY	0.651466	85,786	55,887	65.00
66.00	06600 PHYSICAL THERAPY	0.365665	730,664	267,178	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.732425	127,664	93,504	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.371263	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.410036	387,494	158,886	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	0.561856	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	1.189178	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.933290	258	241	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.069667	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,496,051	611,199	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)		1,496,051		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 7/15/2020 9:50 am	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		26,386		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.473169	178	84	50.00
53.00	05300 ANESTHESIOLOGY	0.334609	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193278	12,080	2,335	54.00
60.00	06000 LABORATORY	0.196864	15,610	3,073	60.00
65.00	06500 RESPIRATORY THERAPY	0.651466	4,781	3,115	65.00
66.00	06600 PHYSICAL THERAPY	0.365665	802	293	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.732425	5,204	3,812	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.371263	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.410036	17,484	7,169	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.074885	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.065890	0	0	88.01
90.00	09000 CLINIC	0.561856	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	1.189178	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.933290	1,256	1,172	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.069667	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		57,395	21,053	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)		57,395		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 7/15/2020 9:50 am	
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	0.473169	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.334609	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193278	0	0	54.00
60.00	06000 LABORATORY	0.196864	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.651466	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.365665	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.732425	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.371263	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.410036	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.074885	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.065890	0	0	88.01
90.00	09000 CLINIC	0.561856	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	1.189178	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.933290	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.069667	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 04/01/2019 To 03/31/2020	Worksheet E Part B Date/Time Prepared: 7/15/2020 9:50 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,231,005	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)		6,231,005	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)		6,293,315	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)		38,545	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,409,808	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)		3,844,962	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)		3,844,962	30.00
31.00	Primary payer payments		1,341	31.00
32.00	Subtotal (line 30 minus line 31)		3,843,621	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)		777,513	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		505,383	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		645,330	36.00
37.00	Subtotal (see instructions)		4,349,004	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)		4,349,004	40.00
40.01	Sequestration adjustment (see instructions)		86,980	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		4,359,793	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-97,769	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/15/2020 9:50 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,913,252		4,194,987	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	12/30/2019	9,356	09/24/2019	127,400	3.01
3.02		03/26/2020	156,209	12/30/2019	37,406	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	09/24/2019	90,362		0	3.50
3.51		06/20/2019	10,488		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)		64,715		164,806	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)		1,977,967		4,359,793	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		328,955		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		97,769	6.02
7.00	Total Medicare program liability (see instructions)		2,306,922		4,262,024	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 04/01/2019
To 03/31/2020Part I
Date/Time Prepared:
7/15/2020 9:50 am

		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		1,631,911		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/24/2019	4,645		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)		-4,645		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)		1,627,266		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		293,635		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,920,901		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 04/01/2019 To 03/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/15/2020 9:50 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days 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: From 04/01/2019 To 03/31/2020	Worksheet E-2	
		Component CCN:14-Z324		Date/Time Prepared: 7/15/2020 9:50 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,370,820	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		617,311	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		960	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)		1,988,131	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,988,131	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)		1,988,131	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		28,028	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,960,103	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)		1,960,103	0	19.00
19.01	Sequestration adjustment (see instructions)		39,202	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,627,266	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		293,635	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
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	Period: From 04/01/2019 To 03/31/2020	Worksheet E-2
		Component CCN:14-Z324		Date/Time Prepared: 7/15/2020 9:50 am
		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 and swing-bed pass-through, see instructions)		0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		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 (see instructions)		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
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments		0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)		0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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		Provider CCN: 14-1324	Period: From 04/01/2019 To 03/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/15/2020 9:50 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,578,742 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)			2,578,742 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,604,529 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)			2,604,529 19.00
20.00	Deductibles (exclude professional component)			320,496 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,284,033 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			2,284,033 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			107,645 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			69,969 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			79,623 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,354,002 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)			2,354,002 30.00
30.01	Sequestration adjustment (see instructions)			47,080 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM			0 30.03
31.00	Interim payments			1,977,967 31.00
31.01	Interim payments-PARHM			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			328,955 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
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 04/01/2019 To 03/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/15/2020 9:50 am	
		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		47,915		1.00
2.00	Medical and other services			301,032	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		48,394	304,042	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)		48,394	304,042	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		57,395	729,879	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)		57,395	729,879	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)		57,395	729,879	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		9,001	425,837	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)		48,394	304,042	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)		48,394	304,042	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)		48,394	304,042	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)		48,394	304,042	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		48,394	304,042	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)		48,394	304,042	40.00
41.00	Interim payments		48,394	304,042	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	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 04/01/2019
To 03/31/2020

Worksheet G

Date/Time Prepared:
7/15/2020 9:50 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,148,199	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	2,134,413	0	0	0	4.00
5.00	Other receivable	1,173,961	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	289,480	0	0	0	7.00
8.00	Prepaid expenses	217,761	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)	5,963,814	0	0	0	11.00
FIXED ASSETS						
12.00	Land	188,327	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-42,902	0	0	0	14.00
15.00	Buildings	17,301,914	0	0	0	15.00
16.00	Accumulated depreciation	-1,838,057	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	5,953,214	0	0	0	23.00
24.00	Accumulated depreciation	-4,769,271	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)	16,793,225	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	2,724,414	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,724,414	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,481,453	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,131,980	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,044,379	0	0	0	38.00
39.00	Payroll taxes payable	50,443	0	0	0	39.00
40.00	Notes and loans payable (short term)	347,099	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	-47,345	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)	2,526,556	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,596,184	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)	17,596,184	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,122,740	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,358,713				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)	5,358,713	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,481,453	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet G-1

Date/Time Prepared:
7/15/2020 9:50 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		5,097,093		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		261,620				2.00
3.00	Total (sum of line 1 and line 2)		5,358,713		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)		5,358,713		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)		5,358,713		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 04/01/2019
To 03/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/15/2020 9:50 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,898,076		2,898,076	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)	2,898,076		2,898,076	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,898,076		2,898,076	17.00
18.00	Ancillary services	5,710,643	34,668,244	40,378,887	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	6,909,789	6,909,789	20.00
20.01	RURAL HEALTH CLINIC II	0	1,265,962	1,265,962	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	1,166,277	1,166,277	27.00
27.01	MCLEANSBORO CLINIC	0	668,556	668,556	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,608,719	44,678,828	53,287,547	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,554,896		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)		26,554,896		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2019
To 03/31/2020

Worksheet G-3

Date/Time Prepared:
7/15/2020 9:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,287,547	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,709,050	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,578,497	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,554,896	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,976,399	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	88,360	6.00
7.00	Income from investments	19,367	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	557	10.00
11.00	Rebates and refunds of expenses	50,752	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	35,443	14.00
15.00	Revenue from rental of living quarters	21,430	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	18,011	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	1,404,099	24.00
24.01	STIMULUS FUNDS	600,000	24.01
25.00	Total other income (sum of lines 6-24)	2,238,019	25.00
26.00	Total (line 5 plus line 25)	261,620	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)	261,620	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8506

From 04/01/2019
To 03/31/2020Date/Time Prepared:
7/15/2020 9:50 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,738,995	0	1,738,995	616	1,739,611
2.00	Physician Assistant	573,291	0	573,291	0	573,291
3.00	Nurse Practitioner	124,037	0	124,037	-1,728	122,309
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	33,007	0	33,007	1	33,008
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	49,026	0	49,026	0	49,026
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)	2,518,356	0	2,518,356	-1,111	2,517,245
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	217,152	217,152	-8,652	208,500
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	217,152	217,152	-8,652	208,500
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,518,356	217,152	2,735,508	-9,763	2,725,745
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	9,761	9,761	-1,794	7,967
30.00	Administrative Costs	1,284,085	701,914	1,985,999	-336,762	1,649,237
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,284,085	711,675	1,995,760	-338,556	1,657,204
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,802,441	928,827	4,731,268	-348,319	4,382,949

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8506

From 04/01/2019
To 03/31/2020Date/Time Prepared:
7/15/2020 9:50 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,739,611	1.00
2.00	Physician Assistant	0	573,291	2.00
3.00	Nurse Practitioner	0	122,309	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	33,008	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	49,026	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	2,517,245	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	208,500	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	208,500	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,725,745	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-21,430	-13,463	29.00
30.00	Administrative Costs	61,231	1,710,468	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	39,801	1,697,005	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	39,801	4,422,750	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8588

From 04/01/2019
To 03/31/2020Date/Time Prepared:
7/15/2020 9:50 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	83,676	0	83,676	-961	82,715
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	173,619	0	173,619	1,728	175,347
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	65	0	65	-1	64
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)	257,360	0	257,360	766	258,126
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	24,295	24,295	8,565	32,860
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	24,295	24,295	8,565	32,860
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	257,360	24,295	281,655	9,331	290,986
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	72,003	72,003	870	72,873
30.00	Administrative Costs	561,044	67,944	628,988	-34,621	594,367
31.00	Total Facility Overhead (sum of lines 29 and 30)	561,044	139,947	700,991	-33,751	667,240
32.00	Total facility costs (sum of lines 22, 28 and 31)	818,404	164,242	982,646	-24,420	958,226

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8588

From 04/01/2019

Date/Time Prepared:

To 03/31/2020

7/15/2020 9:50 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	82,715	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	175,347	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	64	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	258,126	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	32,860	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	32,860	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	290,986	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-58,445	14,428	29.00
30.00	Administrative Costs	37,478	631,845	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-20,967	646,273	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-20,967	937,259	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324

Period:

Worksheet M-2

Component CCN: 14-8506

From 04/01/2019
To 03/31/2020Date/Time Prepared:
7/15/2020 9:50 am

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.66	18,676	4,200	11,172	1.00
2.00	Physician Assistant	1.17	1,950	2,100	2,457	2.00
3.00	Nurse Practitioner	1.48	6,799	2,100	3,108	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.31	27,425		16,737	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	0.12	815		815	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)	5.43	28,240		28,240	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)				2,725,745	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)				2,725,745	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)				1,697,005	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				3,004,480	15.00
16.00	Total overhead (sum of lines 14 and 15)				4,701,485	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				4,701,485	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				4,701,485	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				7,427,230	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324

Period:

Worksheet M-2

Component CCN: 14-8588

From 04/01/2019
To 03/31/2020Date/Time Prepared:
7/15/2020 9:50 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.66	3,647	4,200	2,772		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.88	4,432	2,100	1,848		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.54	8,079		4,620	8,079	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)	1.54	8,079			8,079	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)					290,986	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)					290,986	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)					646,273	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					412,117	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,058,390	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,058,390	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,058,390	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,349,376	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2019 To 03/31/2020	Worksheet M-3 Date/Time Prepared: 7/15/2020 9:50 am		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			7,427,230	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			483,163	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,944,067	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			28,240	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)			28,240	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			245.89	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)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			245.89	245.89	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			8,608	2,869	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			2,116,621	705,458	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	2,822,079	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,866,571	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.)				2,136,499	16.04
16.05	Total program cost (see instructions)			0	2,136,499	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				151,455	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				343,023	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				2,136,499	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				332,186	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				2,468,685	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)				2,468,685	26.00
26.01	Sequestration adjustment (see instructions)				49,374	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,693,784	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)				725,527	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 04/01/2019 To 03/31/2020	Worksheet M-3 Date/Time Prepared: 7/15/2020 9:50 am		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,349,376	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			135,435	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,213,941	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,079	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)			8,079	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			150.26	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)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			150.26	150.26	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			1,856	619	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			278,883	93,011	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	371,894	16.00
16.01	Total program charges (see instructions)(from contractor's records)				428,993	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.)				268,774	16.04
16.05	Total program cost (see instructions)			0	268,774	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				35,926	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				78,613	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				268,774	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				83,342	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				352,116	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)				352,116	26.00
26.01	Sequestration adjustment (see instructions)				7,042	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				595,816	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)				-250,742	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 04/01/2019 To 03/31/2020	Worksheet M-4 Date/Time Prepared: 7/15/2020 9:50 am	
		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)		2,517,245	2,517,245	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.010457	0.012389	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		26,323	31,186	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		94,702	25,106	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		121,025	56,292	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,725,745	2,725,745	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,701,485	4,701,485	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.044401	0.020652	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		208,751	97,095	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		329,776	153,387	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		693	821	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		475.87	186.83	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		510	479	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		242,694	89,492	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)			483,163	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)			332,186	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1324 Component CCN:14-8588	Period: From 04/01/2019 To 03/31/2020	Worksheet M-4 Date/Time Prepared: 7/15/2020 9:50 am	
		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)		258,126	258,126	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.006233	0.013461	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,609	3,475	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		16,263	7,859	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		17,872	11,334	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		290,986	290,986	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,058,390	1,058,390	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.061419	0.038950	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		65,005	41,224	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		82,877	52,558	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		119	257	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		696.45	204.51	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		95	84	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		66,163	17,179	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)			135,435	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)			83,342	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 04/01/2019 To 03/31/2020	Worksheet M-5 Date/Time Prepared: 7/15/2020 9:50 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,693,784	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,693,784		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		725,527		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		2,419,311		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1324 Component CCN:14-8588	Period: From 04/01/2019 To 03/31/2020	Worksheet M-5 Date/Time Prepared: 7/15/2020 9:50 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			346,881	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			03/26/2019	248,935	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)			248,935	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			595,816	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			250,742	6.02
7.00	Total Medicare program liability (see instructions)			345,074	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00