

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

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet S Parts I-III Date/Time Prepared: 8/31/2021 11:45 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/31/2021	Time: 11:45 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 (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FERRELL HOSPITAL (14-1324) for the cost reporting period beginning 04/01/2020 and ending 03/31/2021 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	678,923	869,650	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	384,229	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		646,874		0	10.00
10.01	RURAL HEALTH CLINIC II	0		79,987		0	10.01
10.02	RURAL HEALTH CLINIC III	0		139,733		0	10.02
200.00	Total	0	1,063,152	1,736,244	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 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 11:45 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 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		FERRELL HOSPITAL	141324	99914	1	02/01/2003	N	0	0
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		FERRELL SWINGBED SNF	142324	99914		02/01/2003	N	0	0
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		FERRELL HOSPITAL CLINIC	148506	99914		04/01/2009	N	0	0
15.01	Hospital-Based Health Clinic - RHC		CARMICLINIC	148588	99914		05/23/2018	N	0	0
15.02	Hospital-Based Health Clinic - RHC		MCLEANSBORO FAMILY	148616	99914		03/26/2020	N	0	0
16.00	Hospital-Based Health Clinic - FQHC		MEDICINE							
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2020	03/31/2021		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/31/2021 11:45 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	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
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
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.							
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.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 11:45 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	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
62.00	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		
64.00	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. 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/31/2021 11:45 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 11:45 am	
			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	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 11:45 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.02	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1324		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 11:45 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: DEACONESS HEALTH SYSTEM		Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 600 MARY STREET		PO Box:						142.00	
143.00	City: EVANSVILLE		State: IL		Zip Code: 47710				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part II Date/Time Prepared: 8/31/2021 11:45 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/22/2019	Y 05/22/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part II
Date/Time Prepared:
8/31/2021 11:45 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 04/01/2020
To 03/31/2021Worksheet S-2
Part II
Date/Time Prepared:
8/31/2021 11:45 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/31/2021 11:45 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00	30.00	25	9,125	41,952.00	0	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)						
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	41,952.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	41,952.00	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
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
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 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/31/2021 11:45 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)	1,231	4	1,748			1.00
2.00	HMO and other (see instructions)	0	162				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,022	0	1,022			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	20			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,253	4	2,790			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)	2,253	4	2,790	0.00	118.64	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	9,360	0	23,316	0.00	27.02	26.00
26.01	RURAL HEALTH CLINIC II	2,370	0	7,202	0.00	3.72	26.01
26.02	RURAL HEALTH CLINIC III	281	0	4,691	0.00	3.67	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	153.05	27.00
28.00	Observation Bed Days		9	389			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/31/2021 11:45 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	330	1	493	1.00
2.00 HMO and other (see instructions)			0	46		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	330	1	493	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
26.02 RURAL HEALTH CLINIC III	0.00					26.02
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 04/01/2020
 To 03/31/2021

Worksheet S-8

 Date/Time Prepared:
 8/31/2021 11:45 am

		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	1201 PINE STREET			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	EL DORADO		IL	62930
				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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		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	from
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)				
	CLINIC	13:00	17:00	07:00	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	XIX
		1.00	2.00	3.00	4.00
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)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	SALINE			
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
	Facility hours of operations (1)				
11.00	CLINIC	19:00	07:00	19:00	07:00
		19:00	07:00	19:00	07:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1324

Period:

Worksheet S-8

Component CCN: 14-8506

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 am

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

 Period:
 From 04/01/2020
 To 03/31/2021

Worksheet S-8

 Date/Time Prepared:
 8/31/2021 11:45 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			CARMIL 62821		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
				Sunday		Monday	
				from	to	from	to
				1.00	2.00	3.00	4.00
				Tuesday		from	
				1.00		2.00	
11.00	Facility hours of operations (1)			CLINIC		11.00	
				13:00	17:00	07:00	19:00
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
				Y/N	V	XVIII	XIX
				1.00	2.00	3.00	4.00
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
				County		4.00	
2.00	City, State, ZIP Code, County			WHITE		2.00	
				Tuesday	Wednesday	Thursday	
				to	from	to	from
				6.00	7.00	8.00	9.00
				10.00			
Facility hours of operations (1)							
11.00	CLINIC			19:00	07:00	19:00	07:00
				19:00	07:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1324

Period:

Worksheet S-8

Component CCN: 14-8588

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 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-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1324
 Component CCN: 14-8616

 Period:
 From 04/01/2020
 To 03/31/2021

Worksheet S-8

 Date/Time Prepared:
 8/31/2021 11:45 am

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1324

Period:

Worksheet S-8

Component CCN: 14-8616

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 am

RHC III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet S-10

Date/Time Prepared:
8/31/2021 11:45 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)		0.643273	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,179,433	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		2,205,789	5.00
6.00	Medicaid charges		7,620,646	6.00
7.00	Medicaid cost (line 1 times line 6)		4,902,156	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)		1,516,934	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)		1,516,934	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)	252,936	0	252,936
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	162,707	0	162,707
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	162,707	0	162,707
			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)		2,489,811	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		416,412	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		640,633	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,849,178	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,413,747	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,576,454	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,093,388	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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		1,212,910	1,212,910	-611,080	601,830	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD		0	0	52,836	52,836	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING		0	0	668,504	668,504	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	399,429	399,429	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117,157	2,115,275	2,232,432	-3,617	2,228,815	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	693,311	190,817	884,128	307,485	1,191,613	5.01
5.02	00591	OTHER ADMIN AND GENERAL	741,265	3,762,057	4,503,322	-215,077	4,288,245	5.02
6.00	00600	MAINTENANCE & REPAIRS	216,978	421,551	638,529	-289,320	349,209	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	282,773	282,773	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,026	6,026	-5,082	944	8.00
9.00	00900	HOUSEKEEPING	337,400	88,126	425,526	-30,698	394,828	9.00
10.00	01000	DIETARY	235,231	164,407	399,638	-169,873	229,765	10.00
11.00	01100	CAFETERIA	0	0	0	145,667	145,667	11.00
13.00	01300	NURSING ADMINISTRATION	293,612	71,434	365,046	-1,830	363,216	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	173,916	32,195	206,111	-648	205,463	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	357,132	357,132	-4,374	352,758	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,704,922	173,880	1,878,802	30,899	1,909,701	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	447,516	317,830	765,346	-196,060	569,286	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	610,515	531,526	1,142,041	-21,759	1,120,282	54.00
60.00	06000	LABORATORY	616,785	921,251	1,538,036	-340,656	1,197,380	60.00
65.00	06500	RESPIRATORY THERAPY	440,122	71,414	511,536	-51,306	460,230	65.00
66.00	06600	PHYSICAL THERAPY	0	632,172	632,172	-2,335	629,837	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	138	138	953,718	953,856	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72,733	72,733	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,973	1,612,546	1,856,519	-5,651	1,850,868	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,935,387	807,364	4,742,751	-300,311	4,442,440	88.00
88.01	08801	RURAL HEALTH CLINIC II	809,346	152,749	962,095	-104,767	857,328	88.01
88.02	08802	RURAL HEALTH CLINIC III	543,499	89,439	632,938	0	632,938	88.02
90.00	09000	CLINIC	79,064	182,006	261,070	-404	260,666	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
90.03	09003	CLINIC - ORTHO	151	225,933	226,084	-4,097	221,987	90.03
91.00	09100	EMERGENCY	517,505	1,642,811	2,160,316	-190,922	1,969,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		938,218	938,218	-364,177	574,041	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,757,655	16,721,207	29,478,862	0	29,478,862	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
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)	12,757,655	16,721,207	29,478,862	0	29,478,862	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet A
Date/Time Prepared:
8/31/2021 11:45 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	601,830	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	52,836	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING	0	668,504	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	399,429	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,073,397	3,302,212	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	-519	1,191,094	5.01
5.02	00591	OTHER ADMIN AND GENERAL	792,910	5,081,155	5.02
6.00	00600	MAINTENANCE & REPAIRS	-264	348,945	6.00
7.00	00700	OPERATION OF PLANT	405,576	688,349	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	944	8.00
9.00	00900	HOUSEKEEPING	165,294	560,122	9.00
10.00	01000	DIETARY	63,359	293,124	10.00
11.00	01100	CAFETERIA	-39,347	106,320	11.00
13.00	01300	NURSING ADMINISTRATION	67,480	430,696	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,786	191,677	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	352,758	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,832	1,915,533	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	569,286	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,333	1,118,949	54.00
60.00	06000	LABORATORY	-947	1,196,433	60.00
65.00	06500	RESPIRATORY THERAPY	0	460,230	65.00
66.00	06600	PHYSICAL THERAPY	0	629,837	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	953,856	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72,733	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-350,118	1,500,750	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	43,525	4,485,965	88.00
88.01	08801	RURAL HEALTH CLINIC II	-3,207	854,121	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	632,938	88.02
90.00	09000	CLINIC	0	260,666	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	221,987	90.03
91.00	09100	EMERGENCY	0	1,969,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-574,041	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,633,811	31,112,673	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
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)	1,633,811	31,112,673	200.00

RECLASSIFICATIONS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/31/2021 11:45 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COSTS				
1.00	CAFETERIA	11.00	91,122	54,545	1.00
	TOTALS		91,122	54,545	
	B - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	357,629	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	743	2.00
3.00	LABORATORY	60.00	0	921	3.00
	TOTALS		0	359,293	
	C - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,117	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	36,894	2.00
	TOTALS		0	51,011	
	D - PROPERTY TAXES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,884	1.00
	TOTALS		0	4,884	
	E - RHC BUSINESS OFFICE RECLASS				
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	244,215	64,698	1.00
	TOTALS		244,215	64,698	
	F - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT - NEW WING	1.02	0	668,504	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	362,535	2.00
	TOTALS		0	1,031,039	
	H - EFM BUILDING RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	43,329	1.00
2.00	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	52,836	2.00
	TOTALS		0	96,165	
	I - BILLABLE OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	40,835	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	40,835	
	K - IMPLANT EXPENSE				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	72,733	1.00
	TOTALS		0	72,733	
	L - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	985,616	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
	TOTALS		0	985,616	
	M - PLANT OPERATIONS RECLASS				
1.00	OPERATION OF PLANT	7.00	0	282,773	1.00
	TOTALS		0	282,773	
	N - RHC RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	10,308	51,130	1.00
	TOTALS		10,308	51,130	
	O - HOSPITALIST RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	115,090	1.00
	TOTALS		0	115,090	
500.00	Grand Total: Increases		345,645	3,209,812	500.00

RECLASSIFICATIONS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/31/2021 11:45 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	91,122	54,545	0		1.00
	TOTALS		91,122	54,545			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	359,293	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	359,293			
	C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.02	0	51,011	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	51,011			
	D - PROPERTY TAXES						
1.00	INTEREST EXPENSE	113.00	0	4,884	13		1.00
	TOTALS		0	4,884			
	E - RHC BUSINESS OFFICE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	244,215	64,698	0		1.00
	TOTALS		244,215	64,698			
	F - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,031,039	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,031,039			
	H - EFM BUILDING RENT						
1.00	RURAL HEALTH CLINIC	88.00	0	52,836	10		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	43,329	10		2.00
	TOTALS		0	96,165			
	I - BILLABLE OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	39,329	0		1.00
2.00	OPERATING ROOM	50.00	0	1,506	0		2.00
	TOTALS		0	40,835			
	K - IMPLANT EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	72,733	0		1.00
	TOTALS		0	72,733			
	L - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,617	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	1,428	0		2.00
3.00	OTHER ADMIN AND GENERAL	5.02	0	164,066	0		3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	6,547	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	5,082	0		5.00
6.00	HOUSEKEEPING	9.00	0	30,698	0		6.00
7.00	DIETARY	10.00	0	24,206	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	1,830	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	648	0		9.00
10.00	NONPHYSICIAN ANESTHETISTS	19.00	0	4,374	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	84,191	0		11.00
12.00	OPERATING ROOM	50.00	0	194,554	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,502	0		13.00
14.00	LABORATORY	60.00	0	341,577	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	11,977	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	2,335	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,651	0		17.00
18.00	CLINIC	90.00	0	404	0		18.00
19.00	CLINIC - ORTHO	90.03	0	4,097	0		19.00
20.00	EMERGENCY	91.00	0	75,832	0		20.00
	TOTALS		0	985,616			
	M - PLANT OPERATIONS RECLASS						
1.00	MAINTENANCE & REPAIRS	6.00	0	282,773	0		1.00
	TOTALS		0	282,773			
	N - RHC RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	10,308	51,130	0		1.00
	TOTALS		10,308	51,130			
	O - HOSPITALIST RECLASS						
1.00	EMERGENCY	91.00	0	115,090	0		1.00
	TOTALS		0	115,090			
500.00	Grand Total: Decreases		345,645	3,209,812			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part I
Date/Time Prepared:
8/31/2021 11:45 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	188,327	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,503,697	0	0	0	5,299,112	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	4,353,507	23,840,068	0	23,840,068	0	6.00
7.00	HIT designated Assets	1,581,457	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,626,988	23,840,068	0	23,840,068	5,299,112	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,626,988	23,840,068	0	23,840,068	5,299,112	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	11,204,585	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	28,193,575	0				6.00
7.00	HIT designated Assets	1,581,457	0				7.00
8.00	Subtotal (sum of lines 1-7)	41,167,944	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	41,167,944	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part II
Date/Time Prepared:
8/31/2021 11:45 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	1,212,910	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WING	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,212,910	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	1,212,910				1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0				1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WING	0	0				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,212,910				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part III
Date/Time Prepared:
8/31/2021 11:45 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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	11,392,912	0	11,392,912	0.276742	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0.000000	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WING	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	29,775,032	0	29,775,032	0.723258	0	2.00
3.00	Total (sum of lines 1-2)	41,167,944	0	41,167,944	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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	181,871	43,329	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	52,836	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WING	0	0	0	668,504	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	362,535	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,212,910	96,165	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)	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	357,629	14,117	4,884	0	601,830	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	52,836	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WING	0	0	0	0	668,504	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	36,894	0	0	399,429	2.00
3.00	Total (sum of lines 1-2)	357,629	51,011	4,884	0	1,722,599	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/31/2021 11:45 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 #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - EFM BLD (chapter 2)			0CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - NEW WING (chapter 2)			0CAP REL COSTS-BLDG & FIXT - NEW WING	1.02	0	1.02
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	-20,316	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-84,734	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	-2,606	OTHER ADMIN AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-19,000	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	-3,201			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	2,966,086			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-39,347	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-9,120	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	-13,786	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - 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
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - NEW WING			0CAP REL COSTS-BLDG & FIXT - NEW WING	1.02	0	26.02
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 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/31/2021 11:45 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 #		
1.00	2.00			3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	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	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LOBBYING DUES	A	-10,099	OTHER ADMIN AND GENERAL	5.02	0	33.00
34.00	PROVIDER TAX OFFSET	A	-553,725	INTEREST EXPENSE	113.00	0	34.00
35.00	CARMI CLINIC MISC REVENUE	B	-38,435	RURAL HEALTH CLINIC II	88.01	0	35.00
35.01	A & G MISC REVENUE	B	-519	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	35.01
35.02	A & G PURCHASE DISCOUNTS	B	-631	OTHER ADMIN AND GENERAL	5.02	0	35.02
35.03	340B OFFSET	A	-525,190	DRUGS CHARGED TO PATIENTS	73.00	0	35.03
35.04	NON ALLOWABLE ADVERTISING	A	-10,267	OTHER ADMIN AND GENERAL	5.02	0	35.04
35.05	NON ALLOWABLE ADVERTISING - HUMAN RE	A	-1,299	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,633,811				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 04/01/2020
To 03/31/2021

Worksheet A-8-1

Date/Time Prepared:
8/31/2021 11:45 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	1,074,696	0	1.00
2.00	5.02	OTHER ADMIN AND GENERAL	DHS-A&G	1,816,064	1,020,000	2.00
3.00	7.00	OPERATION OF PLANT	DHS-OPERATION PLANT	405,576	0	3.00
3.01	9.00	HOUSEKEEPING	DHS- HOUSEKEEPING	165,294	0	3.01
4.00	10.00	DIETARY	DHS- DIETARY	63,359	0	4.00
4.01	13.00	NURSING ADMINISTRATION	DHS- NURSING ADMIN	68,137	0	4.01
4.02	73.00	DRUGS CHARGED TO PATIENTS	DHS- PHARMACY	259,806	0	4.02
4.03	30.00	ADULTS & PEDIATRICS	DHS- CASE MANAGEMENT	5,832	0	4.03
4.04	88.00	RURAL HEALTH CLINIC	DHS- EL DORADO	12,868	0	4.04
4.05	88.01	RURAL HEALTH CLINIC II	DHS- CARMi	35,228	0	4.05
4.06	88.00	RURAL HEALTH CLINIC	DHS- FERRELL FAMILY	39,777	0	4.06
4.07	5.02	OTHER ADMIN AND GENERAL	DHS- RHC BUSINESS OFFICE	39,449	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,986,086	1,020,000	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	
	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 04/01/2020
To 03/31/2021

Worksheet A-8-1

Date/Time Prepared:
8/31/2021 11:45 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	1,074,696	0		1.00
2.00	796,064	0		2.00
3.00	405,576	0		3.00
3.01	165,294	0		3.01
4.00	63,359	0		4.00
4.01	68,137	0		4.01
4.02	259,806	0		4.02
4.03	5,832	0		4.03
4.04	12,868	0		4.04
4.05	35,228	0		4.05
4.06	39,777	0		4.06
4.07	39,449	0		4.07
5.00	2,966,086			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			6.00
7.00			7.00
8.00			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 04/01/2020
To 03/31/2021

Worksheet A-8-2

Date/Time Prepared:
8/31/2021 11:45 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	6.00	MAINTENANCE & REPAIRS	264	264	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	657	657	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	115,090	0	115,090	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,333	1,333	0	0	0	4.00
5.00	60.00	LABORATORY	947	947	0	0	0	5.00
6.00	91.00	EMERGENCY	1,439,886	0	1,439,886	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			1,558,177	3,201	1,554,976		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	6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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	6.00	MAINTENANCE & REPAIRS	0	0	0	264		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	657		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,333		4.00
5.00	60.00	LABORATORY	0	0	0	947		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,201		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1324		Period: From 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 11:45 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	1,563.00	2,532.00	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)					132,777	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					161,314	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					306,154	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)					306,154	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)					306,154	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 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 11:45 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	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)	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)						306,154	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						2,203	61.00
62.00	Supplies (see instructions)						2,949	62.00
63.00	Total allowance (sum of lines 57-62)						311,306	63.00
64.00	Total cost of outside supplier services (from your records)						241,488	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 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 11:45 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	67.00	1,147.00	779.00	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)						5,394	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						92,334	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						47,036	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						144,764	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)						144,764	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)						144,764	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 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 11:45 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)					144,764	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)					144,764	63.00
64.00	Total cost of outside supplier services (from your records)					113,579	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 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 11:45 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	4.00	110.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	77.36	77.36	58.02	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.68	38.68	29.01			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)						309	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						8,510	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)						8,819	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)						8,819	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 04/01/2020
To 03/31/2021Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
8/31/2021 11:45 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		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)	77.36	58.02	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					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)					6,487	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 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - EFM BLD	BLDG & FIXT - NEW WING	MVBLE EQUIP	
				1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS			0	1.00	1.01	1.02	2.00	
1.00	00100	CAP REL COSTS-BLDG & FIXT	601,830	601,830				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	52,836	0	52,836			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING	668,504	0	0	668,504		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	399,429				399,429	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,302,212	5,091	0	0	2,659	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,191,094	456	0	2,051	238	5.01
5.02	00591	OTHER ADMIN AND GENERAL	5,081,155	120,782	0	131,942	63,089	5.02
6.00	00600	MAINTENANCE & REPAIRS	348,945	101,269	0	0	52,896	6.00
7.00	00700	OPERATION OF PLANT	688,349	0	586	0	944	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	944	9,726	0	0	5,080	8.00
9.00	00900	HOUSEKEEPING	560,122	3,253	133	0	1,912	9.00
10.00	01000	DIETARY	293,124	17,897	0	28,277	9,348	10.00
11.00	01100	CAFETERIA	106,320	0	0	19,088	0	11.00
13.00	01300	NURSING ADMINISTRATION	430,696	990	0	0	517	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	191,677	27,607	0	0	14,420	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	352,758	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,915,533	81,518	0	125,632	42,579	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	569,286	31,913	0	144,877	16,669	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,118,949	25,612	0	49,969	13,378	54.00
60.00	06000	LABORATORY	1,196,433	11,612	0	31,314	6,065	60.00
65.00	06500	RESPIRATORY THERAPY	460,230	12,193	0	7,020	6,369	65.00
66.00	06600	PHYSICAL THERAPY	629,837	11,235	0	12,265	5,868	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	953,856	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,733	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,500,750	6,301	0	23,821	3,291	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,485,965	74,211	52,117	7,829	122,682	88.00
88.01	08801	RURAL HEALTH CLINIC II	854,121	44,907	0	0	23,456	88.01
88.02	08802	RURAL HEALTH CLINIC III	632,938	0	0	0	0	88.02
90.00	09000	CLINIC	260,666	0	0	13,626	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
90.03	09003	CLINIC - ORTHO	221,987	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,969,394	15,257	0	65,508	7,969	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)	31,112,673	601,830	52,836	663,219	399,429	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	5,285	0	190.00
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)	31,112,673	601,830	52,836	668,504	399,429	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	
			4.00	5.01	5A.01	5.02	6.00	
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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,309,962					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	568,454	1,762,293				5.01
5.02	00591	OTHER ADMIN AND GENERAL	170,982	0	5,567,950	5,567,950		5.02
6.00	00600	MAINTENANCE & REPAIRS	65,762	0	568,872	123,996	692,868	6.00
7.00	00700	OPERATION OF PLANT	0	0	689,879	150,372	1,364	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	15,750	3,433	7,340	8.00
9.00	00900	HOUSEKEEPING	239,865	0	805,285	175,527	2,763	9.00
10.00	01000	DIETARY	79,806	0	428,452	93,389	30,510	10.00
11.00	01100	CAFETERIA	50,604	0	176,012	38,365	11,478	11.00
13.00	01300	NURSING ADMINISTRATION	22,069	0	454,272	99,017	747	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,755	0	332,459	72,466	20,834	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	352,758	76,890	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	551,735	136,856	2,853,853	622,051	137,065	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	112,576	62,279	937,600	204,368	111,203	50.00
53.00	05300	ANESTHESIOLOGY	0	37,715	37,715	8,221	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,932	377,479	1,740,319	379,336	49,376	54.00
60.00	06000	LABORATORY	282,221	386,894	1,914,539	417,310	27,593	60.00
65.00	06500	RESPIRATORY THERAPY	101,653	37,818	625,283	136,292	13,423	65.00
66.00	06600	PHYSICAL THERAPY	0	83,775	742,980	161,947	15,854	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,299	1,000,155	218,003	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,799	79,532	17,336	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,381	173,234	1,757,778	383,141	19,079	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	474,157	223,825	5,440,786	1,185,915	181,961	88.00
88.01	08801	RURAL HEALTH CLINIC II	81,367	37,126	1,040,977	226,901	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	26,309	659,247	143,695	0	88.02
90.00	09000	CLINIC	36,336	18,727	329,355	71,789	8,194	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
90.03	09003	CLINIC - ORTHO	0	566	222,553	48,510	0	90.03
91.00	09100	EMERGENCY	168,307	106,592	2,333,027	508,528	50,906	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)	3,309,962	1,762,293	31,107,388	5,566,798	689,690	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	5,285	1,152	3,178	190.00
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)	3,309,962	1,762,293	31,112,673	5,567,950	692,868	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING					1.02
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	841,615				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,933	35,456			8.00
9.00	00900	HOUSEKEEPING	3,363	6,839	993,777		9.00
10.00	01000	DIETARY	37,133	251	44,497	634,232	10.00
11.00	01100	CAFETERIA	13,970	0	16,741	0	11.00
13.00	01300	NURSING ADMINISTRATION	909	0	1,090	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,357	0	30,385	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	166,819	22,003	199,900	634,232	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	135,343	3,095	162,182	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,095	1,353	72,012	0	54.00
60.00	06000	LABORATORY	33,583	0	40,243	0	60.00
65.00	06500	RESPIRATORY THERAPY	16,337	0	19,577	0	65.00
66.00	06600	PHYSICAL THERAPY	19,296	1,017	23,122	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,221	0	27,826	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	221,460	297	265,374	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	9,972	0	11,950	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	0	90.03
91.00	09100	EMERGENCY	61,956	601	74,243	0	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)	837,747	35,456	989,142	634,232	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,868	0	4,635	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
194.01	07951	340B	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	841,615	35,456	993,777	634,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	16.00	19.00	24.00	25.00	
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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING						1.02
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	00501	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	558,798					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	493,820				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	429,648			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	329,992	136,682	0	5,171,412	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,387	0	0	1,635,230	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	429,648	475,584	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,227	0	2,335,048	0	54.00
60.00	06000	LABORATORY	0	13,227	0	2,481,703	0	60.00
65.00	06500	RESPIRATORY THERAPY	60,771	13,227	0	897,582	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,818	0	973,034	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,218,158	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	96,868	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,217,332	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,354,948	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,267,878	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	802,942	0	88.02
90.00	09000	CLINIC	0	132,273	0	568,066	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
90.03	09003	CLINIC - ORTHO	0	0	0	271,507	0	90.03
91.00	09100	EMERGENCY	100,648	176,366	0	3,327,263	0	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)	558,798	493,820	429,648	31,094,555	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	18,118	0	190.00
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	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	558,798	493,820	429,648	31,112,673	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description		Total	
		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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING	1.02
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
88.02	08802	RURAL HEALTH CLINIC III	88.02
90.00	09000	CLINIC	90.00
90.01	09001	CLINIC - MCLEANSBORO	90.01
90.02	09002	CLINIC - CHF	90.02
90.03	09003	CLINIC - ORTHO	90.03
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			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
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		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - EFM BLD	BLDG & FIXT - NEW WING	MVBLE EQUIP	
				1.00	1.01	1.02	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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,091	0	0	2,659	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	456	0	2,051	238	5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	120,782	0	131,942	63,089	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	101,269	0	0	52,896	6.00
7.00	00700	OPERATION OF PLANT	0	0	586	0	944	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,726	0	0	5,080	8.00
9.00	00900	HOUSEKEEPING	0	3,253	133	0	1,912	9.00
10.00	01000	DIETARY	0	17,897	0	28,277	9,348	10.00
11.00	01100	CAFETERIA	0	0	0	19,088	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	990	0	0	517	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,607	0	0	14,420	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	81,518	0	125,632	42,579	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	31,913	0	144,877	16,669	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,612	0	49,969	13,378	54.00
60.00	06000	LABORATORY	0	11,612	0	31,314	6,065	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,193	0	7,020	6,369	65.00
66.00	06600	PHYSICAL THERAPY	0	11,235	0	12,265	5,868	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	6,301	0	23,821	3,291	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	74,211	52,117	7,829	122,682	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	44,907	0	0	23,456	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	13,626	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
90.03	09003	CLINIC - ORTHO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	15,257	0	65,508	7,969	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)	0	601,830	52,836	663,219	399,429	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	5,285	0	190.00
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	601,830	52,836	668,504	399,429	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	
			2A	4.00	5.01	5.02	6.00	
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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,750	7,750				4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,745	1,330	4,075			5.01
5.02	00591	OTHER ADMIN AND GENERAL	315,813	400	0	316,213		5.02
6.00	00600	MAINTENANCE & REPAIRS	154,165	154	0	7,042	161,361	6.00
7.00	00700	OPERATION OF PLANT	1,530	0	0	8,540	318	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,806	0	0	195	1,709	8.00
9.00	00900	HOUSEKEEPING	5,298	562	0	9,969	643	9.00
10.00	01000	DIETARY	55,522	187	0	5,304	7,106	10.00
11.00	01100	CAFETERIA	19,088	118	0	2,179	2,673	11.00
13.00	01300	NURSING ADMINISTRATION	1,507	52	0	5,623	174	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,027	231	0	4,116	4,852	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	4,367	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	249,729	1,292	315	35,328	31,921	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	193,459	264	143	11,607	25,898	50.00
53.00	05300	ANESTHESIOLOGY	0	0	87	467	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,959	363	870	21,543	11,499	54.00
60.00	06000	LABORATORY	48,991	661	905	23,700	6,426	60.00
65.00	06500	RESPIRATORY THERAPY	25,582	238	87	7,740	3,126	65.00
66.00	06600	PHYSICAL THERAPY	29,368	0	193	9,197	3,692	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	107	12,381	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	16	985	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,413	118	399	21,760	4,443	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	256,839	1,110	516	67,345	42,378	88.00
88.01	08801	RURAL HEALTH CLINIC II	68,363	191	86	12,886	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	61	8,161	0	88.02
90.00	09000	CLINIC	13,626	85	43	4,077	1,908	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
90.03	09003	CLINIC - ORTHO	0	0	1	2,755	0	90.03
91.00	09100	EMERGENCY	88,734	394	246	28,881	11,855	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)	1,717,314	7,750	4,075	316,148	160,621	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	5,285	0	0	65	740	190.00
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)	1,722,599	7,750	4,075	316,213	161,361	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING						1.02
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	10,388					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	110	16,820				8.00
9.00	00900	HOUSEKEEPING	42	3,244	19,758			9.00
10.00	01000	DIETARY	458	119	885	69,581		10.00
11.00	01100	CAFETERIA	172	0	333	0	24,563	11.00
13.00	01300	NURSING ADMINISTRATION	11	0	22	0	265	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	313	0	604	0	1,179	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,059	10,438	3,974	69,581	6,589	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,671	1,468	3,224	0	1,345	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	742	642	1,432	0	1,851	54.00
60.00	06000	LABORATORY	415	0	800	0	3,371	60.00
65.00	06500	RESPIRATORY THERAPY	202	0	389	0	1,213	65.00
66.00	06600	PHYSICAL THERAPY	238	483	460	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	287	0	553	0	602	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,732	141	5,276	0	5,663	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	123	0	238	0	434	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
90.03	09003	CLINIC - ORTHO	0	0	0	0	42	90.03
91.00	09100	EMERGENCY	765	285	1,476	0	2,009	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)	10,340	16,820	19,666	69,581	24,563	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	48	0	92	0	0	190.00
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)	10,388	16,820	19,758	69,581	24,563	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	16.00	19.00	24.00	25.00	
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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING						1.02
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	7,654					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53,322				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	4,367			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,520	14,759		430,505	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	923	0		240,002	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		554	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,428		129,329	0	54.00
60.00	06000	LABORATORY	0	1,428		86,697	0	60.00
65.00	06500	RESPIRATORY THERAPY	832	1,428		40,837	0	65.00
66.00	06600	PHYSICAL THERAPY	0	952		44,583	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		12,488	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		1,001	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		61,575	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0		382,000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		81,526	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		8,222	0	88.02
90.00	09000	CLINIC	0	14,283		34,817	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0		0	0	90.01
90.02	09002	CLINIC - CHF	0	0		0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0		2,798	0	90.03
91.00	09100	EMERGENCY	1,379	19,044		155,068	0	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)	7,654	53,322	0	1,712,002	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		6,230	0	190.00
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			4,367	4,367	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,654	53,322	4,367	1,722,599	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description		Total	
		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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING	1.02
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
88.02	08802	RURAL HEALTH CLINIC III	88.02
90.00	09000	CLINIC	90.00
90.01	09001	CLINIC - MCLEANSBORO	90.01
90.02	09002	CLINIC - CHF	90.02
90.03	09003	CLINIC - ORTHO	90.03
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			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
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		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (FTE'S)	
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - EFM BLD (SQUARE FEET)	BLDG & FIXT - NEW WING (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)		
			1.00	1.01	1.02	2.00		
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	38,302					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD		10,366				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING	0	0	33,901			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				48,668		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	324	0		324	14,848	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	29	0	104	29	2,550	5.01
5.02	00591	OTHER ADMIN AND GENERAL	7,687	0	6,691	7,687	767	5.02
6.00	00600	MAINTENANCE & REPAIRS	6,445	0	0	6,445	295	6.00
7.00	00700	OPERATION OF PLANT	0	115	0	115	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	619	0	0	619	0	8.00
9.00	00900	HOUSEKEEPING	207	26	0	233	1,076	9.00
10.00	01000	DIETARY	1,139	0	1,434	1,139	358	10.00
11.00	01100	CAFETERIA	0	0	968	0	227	11.00
13.00	01300	NURSING ADMINISTRATION	63	0	0	63	99	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,757	0	0	1,757	443	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,188	0	6,371	5,188	2,475	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,031	0	7,347	2,031	505	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,630	0	2,534	1,630	695	54.00
60.00	06000	LABORATORY	739	0	1,588	739	1,266	60.00
65.00	06500	RESPIRATORY THERAPY	776	0	356	776	456	65.00
66.00	06600	PHYSICAL THERAPY	715	0	622	715	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	401	0	1,208	401	226	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,723	10,225	397	14,948	2,127	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,858	0	0	2,858	365	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	691	0	163	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
90.03	09003	CLINIC - ORTHO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	971	0	3,322	971	755	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)	38,302	10,366	33,633	48,668	14,848	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	268	0	0	190.00
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)	601,830	52,836	668,504	399,429	3,309,962	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.712757	5.097048	19.719300	8.207220	222.923087	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					7,750	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.521956	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 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.01	5A.02	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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	48,338,017					5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	-5,567,950	25,544,723			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	568,872	58,431		6.00
7.00	00700	OPERATION OF PLANT	0	0	689,879	115	58,316	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	15,750	619	619	8.00
9.00	00900	HOUSEKEEPING	0	0	805,285	233	233	9.00
10.00	01000	DIETARY	0	0	428,452	2,573	2,573	10.00
11.00	01100	CAFETERIA	0	0	176,012	968	968	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	454,272	63	63	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	332,459	1,757	1,757	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	352,758	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,753,805	0	2,853,853	11,559	11,559	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,708,239	0	937,600	9,378	9,378	50.00
53.00	05300	ANESTHESIOLOGY	1,034,475	0	37,715	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,353,792	0	1,740,319	4,164	4,164	54.00
60.00	06000	LABORATORY	10,612,419	0	1,914,539	2,327	2,327	60.00
65.00	06500	RESPIRATORY THERAPY	1,037,312	0	625,283	1,132	1,132	65.00
66.00	06600	PHYSICAL THERAPY	2,297,842	0	742,980	1,337	1,337	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,269,914	0	1,000,155	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	186,494	0	79,532	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,751,614	0	1,757,778	1,609	1,609	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,139,269	0	5,440,786	15,345	15,345	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,018,318	0	1,040,977	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	721,632	0	659,247	0	0	88.02
90.00	09000	CLINIC	513,666	0	329,355	691	691	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
90.03	09003	CLINIC - ORTHO	15,534	0	222,553	0	0	90.03
91.00	09100	EMERGENCY	2,923,692	0	2,333,027	4,293	4,293	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)	48,338,017	-5,567,950	25,539,438	58,163	58,048	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	5,285	268	268	190.00
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)	1,762,293		5,567,950	692,868	841,615	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.036458		0.217969	11.857884	14.431974	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,075		316,213	161,361	10,388	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000084		0.012379	2.761565	0.178133	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 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATI ENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING						1.02
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	180,668					8.00
9.00	00900	HOUSEKEEPING	34,847	57,464				9.00
10.00	01000	DIETARY	1,279	2,573	1,748			10.00
11.00	01100	CAFETERIA	0	968	0	191,912		11.00
13.00	01300	NURSING ADMINISTRATION	0	63	0	2,067	87,161	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,757	0	9,215	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	112,117	11,559	1,748	51,472	51,472	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,770	9,378	0	10,511	10,511	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,895	4,164	0	14,459	0	54.00
60.00	06000	LABORATORY	2	2,327	0	26,336	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,132	0	9,479	9,479	65.00
66.00	06600	PHYSICAL THERAPY	5,183	1,337	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	1,609	0	4,703	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,514	15,345	0	44,248	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	691	0	3,391	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
90.03	09003	CLINIC - ORTHO	0	0	0	332	0	90.03
91.00	09100	EMERGENCY	3,061	4,293	0	15,699	15,699	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)	180,668	57,196	1,748	191,912	87,161	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	268	0	0	0	190.00
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)	35,456	993,777	634,232	256,566	558,798	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.196249	17.293906	362.832952	1.336894	6.411101	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,820	19,758	69,581	24,563	7,654	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.093099	0.343833	39.806064	0.127991	0.087815	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 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		16.00	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
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WING		1.02
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	3,360	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	930	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100	54.00
60.00	06000	LABORATORY	90	60.00
65.00	06500	RESPIRATORY THERAPY	90	65.00
66.00	06600	PHYSICAL THERAPY	90	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	60	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	88.02
90.00	09000	CLINIC	900	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	90.01
90.02	09002	CLINIC - CHF	0	90.02
90.03	09003	CLINIC - ORTHO	0	90.03
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,200	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,360	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	MARKETING	0	194.00
194.01	07951	340B	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)	493,820	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	146.970238	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,296.480000	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	53,322	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	15.869643	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	43.670000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 11:45 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	5,171,412		5,171,412		0	0	30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,635,230		1,635,230		0	0	50.00
53.00	05300	ANESTHESIOLOGY	475,584		475,584		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,335,048		2,335,048		0	0	54.00
60.00	06000	LABORATORY	2,481,703		2,481,703		0	0	60.00
65.00	06500	RESPIRATORY THERAPY	897,582	0	897,582		0	0	65.00
66.00	06600	PHYSICAL THERAPY	973,034	0	973,034		0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,218,158		1,218,158		0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,868		96,868		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,217,332		2,217,332		0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	7,354,948		7,354,948		0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,267,878		1,267,878		0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	802,942		802,942		0	0	88.02
90.00	09000	CLINIC	568,066		568,066		0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0		0		0	0	90.01
90.02	09002	CLINIC - CHF	0		0		0	0	90.02
90.03	09003	CLINIC - ORTHO	271,507		271,507		0	0	90.03
91.00	09100	EMERGENCY	3,327,263		3,327,263		0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	636,420		636,420		0	0	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	31,730,975	0	31,730,975		0	0	200.00
201.00		Less Observation Beds	636,420		636,420				201.00
202.00		Total (see instructions)	31,094,555	0	31,094,555		0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 11:45 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	3,146,790		3,146,790			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	147,380	1,560,859	1,708,239	0.957261	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	60,619	973,856	1,034,475	0.459735	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	699,899	9,653,893	10,353,792	0.225526	0.000000	54.00
60.00	06000	LABORATORY	1,016,686	9,595,733	10,612,419	0.233849	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	285,815	751,497	1,037,312	0.865296	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	992,338	1,305,504	2,297,842	0.423456	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	685,173	584,741	1,269,914	0.959244	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,158	158,336	186,494	0.519416	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,968,683	2,782,931	4,751,614	0.466648	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,139,269	6,139,269			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,018,318	1,018,318			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	721,632	721,632			88.02
90.00	09000	CLINIC	0	513,666	513,666	1.105905	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0.000000	0.000000	90.02
90.03	09003	CLINIC - ORTHO	0	15,534	15,534	17.478241	0.000000	90.03
91.00	09100	EMERGENCY	153,374	2,770,318	2,923,692	1.138035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,082	568,933	607,015	1.048442	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,222,997	39,115,020	48,338,017			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,222,997	39,115,020	48,338,017			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 11:45 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
88.02	08802 RURAL HEALTH CLINIC III				88.02
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
90.03	09003 CLINIC - ORTHO	0.000000			90.03
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

Worksheet C
Part I
Date/Time Prepared:
8/31/2021 11:45 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 11:45 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	3,146,790		3,146,790		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	147,380	1,560,859	1,708,239	0.957261	0.000000
53.00	05300	ANESTHESIOLOGY	60,619	973,856	1,034,475	0.459735	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	699,899	9,653,893	10,353,792	0.225526	0.000000
60.00	06000	LABORATORY	1,016,686	9,595,733	10,612,419	0.233849	0.000000
65.00	06500	RESPIRATORY THERAPY	285,815	751,497	1,037,312	0.865296	0.000000
66.00	06600	PHYSICAL THERAPY	992,338	1,305,504	2,297,842	0.423456	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	685,173	584,741	1,269,914	0.959244	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,158	158,336	186,494	0.519416	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,968,683	2,782,931	4,751,614	0.466648	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,139,269	6,139,269	1.198017	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	1,018,318	1,018,318	1.245071	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	721,632	721,632	1.112675	0.000000
90.00	09000	CLINIC	0	513,666	513,666	1.105905	0.000000
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0.000000	0.000000
90.02	09002	CLINIC - CHF	0	0	0	0.000000	0.000000
90.03	09003	CLINIC - ORTHO	0	15,534	15,534	17.478241	0.000000
91.00	09100	EMERGENCY	153,374	2,770,318	2,923,692	1.138035	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,082	568,933	607,015	1.048442	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	9,222,997	39,115,020	48,338,017		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,222,997	39,115,020	48,338,017		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 11:45 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
88.02	08802 RURAL HEALTH CLINIC III	0.000000			88.02
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
90.03	09003 CLINIC - ORTHO	0.000000			90.03
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 04/01/2020 To 03/31/2021	Worksheet D Part II Date/Time Prepared: 8/31/2021 11:45 am	
				Title XVIII		Hospital	Cost
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	240,002	1,708,239	0.140497	68,788	9,665
53.00	05300	ANESTHESIOLOGY	554	1,034,475	0.000536	36,136	19
54.00	05400	RADIOLOGY-DIAGNOSTIC	129,329	10,353,792	0.012491	318,650	3,980
60.00	06000	LABORATORY	86,697	10,612,419	0.008169	530,113	4,330
65.00	06500	RESPIRATORY THERAPY	40,837	1,037,312	0.039368	143,097	5,633
66.00	06600	PHYSICAL THERAPY	44,583	2,297,842	0.019402	129,189	2,507
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,488	1,269,914	0.009834	332,129	3,266
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,001	186,494	0.005367	16,295	87
73.00	07300	DRUGS CHARGED TO PATIENTS	61,575	4,751,614	0.012959	1,040,004	13,477
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	382,000	6,139,269	0.062222	0	0
88.01	08801	RURAL HEALTH CLINIC II	81,526	1,018,318	0.080059	0	0
88.02	08802	RURAL HEALTH CLINIC III	8,222	721,632	0.011394	0	0
90.00	09000	CLINIC	34,817	513,666	0.067781	0	0
90.01	09001	CLINIC - MCLEANSBORO	0	0	0.000000	0	0
90.02	09002	CLINIC - CHF	0	0	0.000000	0	0
90.03	09003	CLINIC - ORTHO	2,798	15,534	0.180121	0	0
91.00	09100	EMERGENCY	155,068	2,923,692	0.053038	19,662	1,043
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	52,980	607,015	0.087280	5,321	464
200.00		Total (lines 50 through 199)	1,334,477	45,191,227		2,639,384	44,471

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1324		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part IV Date/Time Prepared: 8/31/2021 11:45 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	50.00
53.00	05300	ANESTHESIOLOGY	429,648	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
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
90.03	09003	CLINIC - ORTHO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	429,648	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 11:45 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	1,708,239	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	429,648	0	1,034,475	0.415330	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,353,792	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,612,419	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,037,312	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,297,842	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,269,914	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	186,494	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,751,614	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,139,269	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,018,318	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	721,632	0.000000	88.02
90.00	09000	CLINIC	0	0	0	513,666	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0.000000	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	15,534	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	2,923,692	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	607,015	0.000000	92.00
200.00		Total (lines 50 through 199)	0	429,648	0	45,191,227		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 11:45 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	68,788	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	36,136	15,008	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	318,650	0	0	0
60.00	06000	LABORATORY	0.000000	530,113	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	143,097	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	129,189	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	332,129	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	16,295	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,040,004	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	0	0	0	0
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	0	0
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0
90.03	09003	CLINIC - ORTHO	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	19,662	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,321	0	0	0
200.00		Total (lines 50 through 199)		2,639,384	15,008	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/31/2021 11:45 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	0.957261	0	598,158	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.459735	0	389,019	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225526	0	4,021,649	0	0	54.00
60.00	06000	LABORATORY	0.233849	0	4,489,809	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.865296	0	307,629	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.423456	0	554,194	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.959244	0	242,895	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519416	0	71,616	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.466648	0	1,571,724	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	1.105905	0	890	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
90.03	09003	CLINIC - ORTHO	17.478241	0	4,828	0	0	90.03
91.00	09100	EMERGENCY	1.138035	0	1,163,843	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.048442	0	267,821	0	0	92.00
200.00		Subtotal (see instructions)		0	13,684,075	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	13,684,075	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1324		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part V Date/Time Prepared: 8/31/2021 11:45 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	572,593	0					50.00
53.00	05300	ANESTHESIOLOGY	178,846	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	906,986	0					54.00
60.00	06000	LABORATORY	1,049,937	0					60.00
65.00	06500	RESPIRATORY THERAPY	266,190	0					65.00
66.00	06600	PHYSICAL THERAPY	234,677	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,996	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,198	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	733,442	0					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	RURAL HEALTH CLINIC II							88.01
88.02	08802	RURAL HEALTH CLINIC III							88.02
90.00	09000	CLINIC	984	0					90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0					90.01
90.02	09002	CLINIC - CHF	0	0					90.02
90.03	09003	CLINIC - ORTHO	84,385	0					90.03
91.00	09100	EMERGENCY	1,324,494	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	280,795	0					92.00
200.00		Subtotal (see instructions)	5,903,523	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	5,903,523	0					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/31/2021 11:45 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	0.957261	0	18,970	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.459735	0	2,485	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225526	0	211,946	0	54.00	
60.00	06000	LABORATORY	0.233849	0	136,584	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.865296	0	10,197	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.423456	0	9,957	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.959244	0	10,908	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519416	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.466648	0	23,677	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC					88.00	
88.01	08801	RURAL HEALTH CLINIC II					88.01	
88.02	08802	RURAL HEALTH CLINIC III					88.02	
90.00	09000	CLINIC	1.105905	0	0	0	90.00	
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	0	90.01	
90.02	09002	CLINIC - CHF	0.000000	0	0	0	90.02	
90.03	09003	CLINIC - ORTHO	17.478241	0	0	0	90.03	
91.00	09100	EMERGENCY	1.138035	0	64,159	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.048442	0	8,974	0	92.00	
200.00		Subtotal (see instructions)		0	497,857	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	497,857	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/31/2021 11:45 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	18,159	0		50.00
53.00	05300	ANESTHESIOLOGY	1,142	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,799	0		54.00
60.00	06000	LABORATORY	31,940	0		60.00
65.00	06500	RESPIRATORY THERAPY	8,823	0		65.00
66.00	06600	PHYSICAL THERAPY	4,216	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,463	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,049	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
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
90.03	09003	CLINIC - ORTHO	0	0		90.03
91.00	09100	EMERGENCY	73,015	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,409	0		92.00
200.00		Subtotal (see instructions)	216,015	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	216,015	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/31/2021 11:45 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)			3,179	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,137	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)			1,748	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)			1,022	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,231	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)			1,022	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)			5,171,412	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			3,144	25.00
26.00	Total swing-bed cost (see instructions)			1,675,187	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,496,225	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)			3,496,225	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)			1,636.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,013,978	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)			2,013,978	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/31/2021 11:45 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)					1,297,146	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,311,124	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)					1,672,043	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,672,043	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)					389	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,636.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					636,420	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/31/2021 11:45 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	430,505	5,171,412	0.083247	636,420	52,980
91.00	Nursing School cost	0	5,171,412	0.000000	636,420	0
92.00	Allied health cost	0	5,171,412	0.000000	636,420	0
93.00	All other Medical Education	0	5,171,412	0.000000	636,420	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/31/2021 11:45 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)		3,179	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,137	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)		1,748	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)		1,022	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		20	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4	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)		5,171,412	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		3,144	25.00	
26.00	Total swing-bed cost (see instructions)		1,675,187	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,496,225	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)		3,496,225	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)		1,636.05	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,544	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)		6,544	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/31/2021 11:45 am

		Title XIX		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,012	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,556	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)					389	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,636.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					636,420	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	430,505	5,171,412	0.083247	636,420	52,980	90.00
91.00	Nursing School cost	0	5,171,412	0.000000	636,420	0	91.00
92.00	Allied health cost	0	5,171,412	0.000000	636,420	0	92.00
93.00	All other Medical Education	0	5,171,412	0.000000	636,420	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/31/2021 11:45 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		1,772,786		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.957261	68,788	65,848	50.00
53.00	05300 ANESTHESIOLOGY	0.459735	36,136	16,613	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.225526	318,650	71,864	54.00
60.00	06000 LABORATORY	0.233849	530,113	123,966	60.00
65.00	06500 RESPIRATORY THERAPY	0.865296	143,097	123,821	65.00
66.00	06600 PHYSICAL THERAPY	0.423456	129,189	54,706	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.959244	332,129	318,593	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.519416	16,295	8,464	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.466648	1,040,004	485,316	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
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	1.105905	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	0.000000	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
90.03	09003 CLINIC - ORTHO	17.478241	0	0	90.03
91.00	09100 EMERGENCY	1.138035	19,662	22,376	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.048442	5,321	5,579	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,639,384	1,297,146	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,639,384		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/31/2021 11:45 am	
Cost Center Description		Title XVIII	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	0.957261	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.459735	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.225526	45,244	10,204	54.00
60.00	06000 LABORATORY	0.233849	129,720	30,335	60.00
65.00	06500 RESPIRATORY THERAPY	0.865296	62,016	53,662	65.00
66.00	06600 PHYSICAL THERAPY	0.423456	786,011	332,841	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.959244	164,545	157,839	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.519416	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.466648	327,816	152,975	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
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	1.105905	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	0.000000	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
90.03	09003 CLINIC - ORTHO	17.478241	0	0	90.03
91.00	09100 EMERGENCY	1.138035	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.048442	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,515,352	737,856	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,515,352		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/31/2021 11:45 am	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		5,666		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.957261	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.459735	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.225526	2,162	488	54.00
60.00	06000 LABORATORY	0.233849	3,097	724	60.00
65.00	06500 RESPIRATORY THERAPY	0.865296	612	530	65.00
66.00	06600 PHYSICAL THERAPY	0.423456	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.959244	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.519416	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.466648	4,605	2,149	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.198017	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.245071	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	1.112675	0	0	88.02
90.00	09000 CLINIC	1.105905	0	0	90.00
90.01	09001 CLINIC - MCLEANSBORO	0.000000	0	0	90.01
90.02	09002 CLINIC - CHF	0.000000	0	0	90.02
90.03	09003 CLINIC - ORTHO	17.478241	0	0	90.03
91.00	09100 EMERGENCY	1.138035	985	1,121	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.048442	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		11,461	5,012	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		11,461		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1324 Component CCN: 14-Z324	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/31/2021 11:45 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	0.957261	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.459735	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225526	0	0	54.00
60.00	06000	LABORATORY	0.233849	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.865296	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.423456	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.959244	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519416	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.466648	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.198017	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.245071	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.112675	0	0	88.02
90.00	09000	CLINIC	1.105905	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	90.02
90.03	09003	CLINIC - ORTHO	17.478241	0	0	90.03
91.00	09100	EMERGENCY	1.138035	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.048442	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 04/01/2020 To 03/31/2021	Worksheet E Part B Date/Time Prepared: 8/31/2021 11:45 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,903,523 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)			5,903,523 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)			5,962,558 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)			39,467 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,810,457 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			4,112,634 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			4,112,634 30.00
31.00	Primary payer payments			1,962 31.00
32.00	Subtotal (line 30 minus line 31)			4,110,672 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)			537,749 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			349,537 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			518,739 36.00
37.00	Subtotal (see instructions)			4,460,209 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)			4,460,209 40.00
40.01	Sequestration adjustment (see instructions)			7,136 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			3,583,423 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)			869,650 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 04/01/2020
To 03/31/2021Worksheet E-1
Part I
Date/Time Prepared:
8/31/2021 11:45 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		2,199,873		3,762,912	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	09/22/2020	109,002		0	3.01
3.02		10/01/2020	92,396		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	03/09/2021	20,196	09/22/2020	1,499	3.50
3.51			0	10/01/2020	50,369	3.51
3.52			0	03/09/2021	127,621	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)		181,202		-179,489	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,381,075		3,583,423	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		678,923		869,650	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,059,998		4,453,073	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 04/01/2020
To 03/31/2021Part I
Date/Time Prepared:
8/31/2021 11:45 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		1,941,222		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	10/01/2020	98,514		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	03/09/2021	14,591		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)		83,923		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,025,145		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		384,229		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,409,374		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 04/01/2020 To 03/31/2021	Worksheet E-1 Part II Date/Time Prepared: 8/31/2021 11:45 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:

Worksheet E-2

Component CCN: 14-Z324

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 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)		1,688,763	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)		745,235	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,022	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,433,998	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,433,998	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2,433,998	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		20,763	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,413,235	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,413,235	0	19.00
19.01	Sequestration adjustment (see instructions)		3,861	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		2,025,145	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		384,229	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 Component CCN: 14-Z324	Period: From 04/01/2020 To 03/31/2021	Worksheet E-2 Date/Time Prepared: 8/31/2021 11:45 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
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
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, 19.02, 19.25, 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 04/01/2020 To 03/31/2021	Worksheet E-3 Part V Date/Time Prepared: 8/31/2021 11:45 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,311,124	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)		3,311,124	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,344,235	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)		3,344,235	19.00
20.00	Deductibles (exclude professional component)		346,208	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,998,027	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,998,027	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		102,884	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		66,875	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		97,319	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,064,902	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)		3,064,902	30.00
30.01	Sequestration adjustment (see instructions)		4,904	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		2,381,075	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)		678,923	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 04/01/2020 To 03/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 8/31/2021 11:45 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		11,556		1.00
2.00	Medical and other services			216,015	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		11,672	218,175	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)		11,672	218,175	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		11,461	497,857	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)		11,461	497,857	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)		11,461	497,857	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	279,682	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		211	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)		11,672	218,175	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)		11,672	218,175	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		211	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		11,672	218,175	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		11,672	218,175	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		11,672	218,175	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)		11,672	218,175	40.00
41.00	Interim payments		11,672	218,175	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 04/01/2020
To 03/31/2021

Worksheet G

Date/Time Prepared:
8/31/2021 11:45 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	11,005,483	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	1,638,634	0	0	0	4.00
5.00	Other receivable	787,883	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	519,435	0	0	0	7.00
8.00	Prepaid expenses	309,162	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)	14,260,597	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	-42,956	0	0	0	14.00
15.00	Buildings	11,204,585	0	0	0	15.00
16.00	Accumulated depreciation	-2,077,561	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	29,775,032	0	0	0	23.00
24.00	Accumulated depreciation	-5,742,623	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)	33,304,804	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	4,836,125	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,836,125	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	52,401,526	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,744,002	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,228,412	0	0	0	38.00
39.00	Payroll taxes payable	531,397	0	0	0	39.00
40.00	Notes and loans payable (short term)	392,119	0	0	0	40.00
41.00	Deferred income	92,744	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	6,288,819	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)	12,277,493	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	34,441,653	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)	34,441,653	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	46,719,146	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,682,380	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,682,380	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	52,401,526	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-1

Date/Time Prepared:
8/31/2021 11:45 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		3,611,447		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,070,933				2.00
3.00	Total (sum of line 1 and line 2)		5,682,380		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)		5,682,380		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)		5,682,380		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 04/01/2020
To 03/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
8/31/2021 11:45 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,256,408		3,256,408	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,256,408		3,256,408	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,256,408		3,256,408	17.00
18.00	Ancillary services	5,963,377	30,725,825	36,689,202	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	6,139,269	6,139,269	20.00
20.01	RURAL HEALTH CLINIC II	0	1,018,318	1,018,318	20.01
20.02	RURAL HEALTH CLINIC III	0	520,631	520,631	20.02
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	PROVIDER BASED CLINICS	0	736,976	736,976	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,219,785	39,141,019	48,360,804	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,478,862		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)		29,478,862		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1324

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-3

Date/Time Prepared:
8/31/2021 11:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	48,360,804	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,317,521	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,043,283	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,478,862	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,435,579	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	191,913	6.00
7.00	Income from investments	20,316	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	631	10.00
11.00	Rebates and refunds of expenses	84,734	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	39,347	14.00
15.00	Revenue from rental of living quarters	9,120	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	13,786	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	2,853,773	24.00
24.50	COVID-19 PHE Funding	4,292,892	24.50
25.00	Total other income (sum of lines 6-24)	7,506,512	25.00
26.00	Total (line 5 plus line 25)	2,070,933	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)	2,070,933	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8506

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,785,341	0	1,785,341	61,438	1,846,779
2.00	Physician Assistant	540,715	0	540,715	0	540,715
3.00	Nurse Practitioner	121,255	0	121,255	0	121,255
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	38,550	0	38,550	0	38,550
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	61,463	0	61,463	0	61,463
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)	2,547,324	0	2,547,324	61,438	2,608,762
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	164,073	164,073	-1,050	163,023
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	164,073	164,073	-1,050	163,023
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,547,324	164,073	2,711,397	60,388	2,771,785
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	6,734	6,734	-53,755	-47,021
30.00	Administrative Costs	1,388,063	636,557	2,024,620	-306,944	1,717,676
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,388,063	643,291	2,031,354	-360,699	1,670,655
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,935,387	807,364	4,742,751	-300,311	4,442,440

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8506

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 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	1,846,779	1.00
2.00	Physician Assistant	0	540,715	2.00
3.00	Nurse Practitioner	0	121,255	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	38,550	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	61,463	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	2,608,762	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	163,023	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	163,023	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,771,785	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	-9,120	-56,141	29.00
30.00	Administrative Costs	52,645	1,770,321	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,525	1,714,180	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	43,525	4,485,965	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8588

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 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	79,182	0	79,182	-61,438	17,744
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	162,989	0	162,989	0	162,989
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	2,119	0	2,119	0	2,119
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)	244,290	0	244,290	-61,438	182,852
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	17,617	17,617	0	17,617
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	17,617	17,617	0	17,617
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	244,290	17,617	261,907	-61,438	200,469
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	82,367	82,367	-43,329	39,038
30.00	Administrative Costs	565,056	52,765	617,821	0	617,821
31.00	Total Facility Overhead (sum of lines 29 and 30)	565,056	135,132	700,188	-43,329	656,859
32.00	Total facility costs (sum of lines 22, 28 and 31)	809,346	152,749	962,095	-104,767	857,328

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8588

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 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	17,744	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	162,989	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	2,119	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	182,852	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	17,617	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	17,617	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	200,469	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	-38,435	603	29.00
30.00	Administrative Costs	35,228	653,049	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,207	653,652	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,207	854,121	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8616

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 am

		RHC III		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	0	0	0	0	0 1.00
2.00 Physician Assistant	0	0	0	0	0 2.00
3.00 Nurse Practitioner	10,519	0	10,519	0	10,519 3.00
4.00 Visiting Nurse	0	0	0	0	0 4.00
5.00 Other Nurse	0	0	0	0	0 5.00
6.00 Clinical Psychologist	0	0	0	0	0 6.00
7.00 Clinical Social Worker	0	0	0	0	0 7.00
8.00 Laboratory Technician	0	0	0	0	0 8.00
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0 9.00
10.00 Subtotal (sum of lines 1 through 9)	10,519	0	10,519	0	10,519 10.00
11.00 Physician Services Under Agreement	0	0	0	0	0 11.00
12.00 Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00 Other Costs Under Agreement	0	0	0	0	0 13.00
14.00 Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00 Medical Supplies	0	24,762	24,762	0	24,762 15.00
16.00 Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00 Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00 Professional Liability Insurance	0	0	0	0	0 18.00
19.00 Other Health Care Costs	0	0	0	0	0 19.00
20.00 Allowable GME Costs	0	0	0	0	0 20.00
21.00 Subtotal (sum of lines 15 through 20)	0	24,762	24,762	0	24,762 21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	10,519	24,762	35,281	0	35,281 22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	0	0	0	0 23.00
24.00 Dental	0	0	0	0	0 24.00
25.00 Optometry	0	0	0	0	0 25.00
25.01 Telehealth	0	0	0	0	0 25.01
25.02 Chronic Care Management	0	0	0	0	0 25.02
26.00 All other nonreimbursable costs	0	0	0	0	0 26.00
27.00 Nonallowable GME costs	0	0	0	0	0 27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD					
29.00 Facility Costs	0	50,408	50,408	0	50,408 29.00
30.00 Administrative Costs	532,980	14,269	547,249	0	547,249 30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	532,980	64,677	597,657	0	597,657 31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	543,499	89,439	632,938	0	632,938 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324

Period:

Worksheet M-1

Component CCN: 14-8616

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	10,519	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	10,519	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	24,762	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	24,762	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	35,281	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	0	50,408	29.00
30.00	Administrative Costs	0	547,249	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	597,657	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	632,938	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324

Period:

Worksheet M-2

Component CCN: 14-8506

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 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	2.88	16,086	4,200	12,096		1.00
2.00	Physician Assistant	0.99	897	2,100	2,079		2.00
3.00	Nurse Practitioner	1.84	5,533	2,100	3,864		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.71	22,516		18,039	22,516	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	0.09	800			800	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)	5.80	23,316			23,316	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)					2,771,785	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)					2,771,785	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)					1,714,180	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,868,983	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,583,163	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,583,163	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,583,163	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,354,948	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324

Period:

Worksheet M-2

Component CCN: 14-8588

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 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	1.55	3,231	4,200	6,510		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.04	3,971	2,100	2,184		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.59	7,202		8,694	8,694	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.59	7,202			8,694	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)					200,469	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)					200,469	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)					653,652	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					413,757	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,067,409	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,067,409	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,067,409	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,267,878	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324

Period:

Worksheet M-2

Component CCN: 14-8616

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 11:45 am

		RHC III		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.00	0	4,200	0
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.77	4,691	2,100	1,617
4.00	Subtotal (sum of lines 1 through 3)	0.77	4,691		1,617
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.77	4,691		4,691
9.00	Physician Services Under Agreements		0		0
					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)				35,281
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				35,281
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				597,657
15.00	Parent provider overhead allocated to facility (see instructions)				170,004
16.00	Total overhead (sum of lines 14 and 15)				767,661
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				767,661
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				767,661
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				802,942

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2020 To 03/31/2021	Worksheet M-3 Date/Time Prepared: 8/31/2021 11:45 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)			7,354,948	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			224,371	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			7,130,577	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			23,316	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)			23,316	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			305.82	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)			86.31	87.52	8.00
9.00	Rate for Program covered visits (see instructions)			305.82	305.82	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			7,020	2,340	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			2,146,856	715,619	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	2,862,475	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,548,450	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.)				2,181,191	16.04
16.05	Total program cost (see instructions)			0	2,181,191	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				135,986	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				277,631	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				2,181,191	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				128,699	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				2,309,890	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)				2,309,890	26.00
26.01	Sequestration adjustment (see instructions)				3,696	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,659,320	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)				646,874	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

Health Financial Systems		FERRELL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1324	Period: From 04/01/2020 To 03/31/2021	Worksheet M-3	
		Component CCN: 14-8588		Date/Time Prepared: 8/31/2021 11:45 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)			1,267,878	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			210,462	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,057,416	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,694	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)			8,694	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			121.63	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)		86.31	87.52	8.00
9.00	Rate for Program covered visits (see instructions)		121.63	121.63	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,778	592	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		216,258	72,005	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	288,263	16.00
16.01	Total program charges (see instructions)(from contractor's records)			443,678	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.)			195,746	16.04
16.05	Total program cost (see instructions)		0	195,746	16.05
17.00	Primary payer amounts			65	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			43,580	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			76,721	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			195,681	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			129,750	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			325,431	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)			325,431	26.00
26.01	Sequestration adjustment (see instructions)			521	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			244,923	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)			79,987	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: 14-8616	Period: From 04/01/2020 To 03/31/2021	Worksheet M-3 Date/Time Prepared: 8/31/2021 11:45 am		
		Title XVIII	RHC III	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)			802,942	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			174,331	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			628,611	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,691	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)			4,691	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			134.00	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)			86.31	87.52	8.00
9.00	Rate for Program covered visits (see instructions)			134.00	134.00	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			211	70	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			28,274	9,380	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	37,654	16.00
16.01	Total program charges (see instructions)(from contractor's records)				44,280	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.)				20,750	16.04
16.05	Total program cost (see instructions)			0	20,750	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				11,716	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				6,447	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				20,750	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				119,657	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				140,407	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)				140,407	26.00
26.01	Sequestration adjustment (see instructions)				225	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				449	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)				139,733	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 04/01/2020 To 03/31/2021	Worksheet M-4 Date/Time Prepared: 8/31/2021 11:45 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)		2,608,762	2,608,762	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001523	0.003130	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,973	8,165	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		49,606	22,813	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		53,579	30,978	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,771,785	2,771,785	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,583,163	4,583,163	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.019330	0.011176	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		88,593	51,221	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		142,172	82,199	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		363	746	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		391.66	110.19	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		211	418	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		82,640	46,059	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)			224,371	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)			128,699	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1324 Component CCN: 14-8588	Period: From 04/01/2020 To 03/31/2021	Worksheet M-4 Date/Time Prepared: 8/31/2021 11:45 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)		182,852	182,852	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.004224	0.009143	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		772	1,672	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		20,772	10,061	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		21,544	11,733	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		200,469	200,469	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,067,409	1,067,409	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.107468	0.058528	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		114,712	62,473	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		136,256	74,206	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		152	329	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		896.42	225.55	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		107	150	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		95,917	33,833	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)			210,462	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)			129,750	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1324 Component CCN: 14-8616	Period: From 04/01/2020 To 03/31/2021	Worksheet M-4 Date/Time Prepared: 8/31/2021 11:45 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		10,519	10,519	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001008	0.003340	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		11	35	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		4,373	3,241	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,384	3,276	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		35,281	35,281	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		767,661	767,661	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.124260	0.092855	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		95,390	71,281	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		99,774	74,557	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		32	106	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		3,117.94	703.37	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		28	46	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		87,302	32,355	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)			174,331	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)			119,657	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 04/01/2020 To 03/31/2021	Worksheet M-5 Date/Time Prepared: 8/31/2021 11:45 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		1,564,585	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		10/01/2020	61,049	3.01	
3.02		10/19/2020	58,823	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50		03/09/2021	25,137	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)		94,735	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,659,320	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		646,874	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,306,194	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 04/01/2020 To 03/31/2021	Worksheet M-5 Date/Time Prepared: 8/31/2021 11:45 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		409,982	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		10/01/2020	91,645	3.50	
3.51		03/09/2021	73,414	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)		-165,059	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		244,923	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		79,987	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		324,910	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: 14-8616	Period: From 04/01/2020 To 03/31/2021	Worksheet M-5 Date/Time Prepared: 8/31/2021 11:45 am	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			449	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)			449	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			139,733	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			140,182	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00