

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

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

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

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet S
Parts I-III
Date/Time Prepared:
2/27/2020 5:10 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/27/2020	Time: 5:10 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MENDOTA COMMUNITY HOSPITAL (14-1310) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

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	130,141	-761,431	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	112,748	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		385,469		0	10.00
200.00	Total	0	242,889	-375,962	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: 14-1310		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 5:10 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1401 EAST 12TH ST			PO Box:					1.00	
2.00	City: MENDOTA			State: IL		Zip Code: 61342-9216		County: LA SALLE		
		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		MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	N	O	N
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		MENDOTA COMMUNITY HOSPITAL - RHC	148535	99914		02/11/2015	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
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)						10/01/2018	09/30/2019		20.00
21.00	Type of Control (see instructions)						1			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim 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.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural 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.					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.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
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: 14-1310		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 5:10 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00
			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
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
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2/27/2020 5:10 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					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)					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.					75.00

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N					111.00
						1.00	
						2.00	
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		0	
						1.00	
						2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N					122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 5:10 pm	
		1.00		2.00			
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		149006		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131		141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:				142.00	
143.00	City: PEORIA	State: IL		Zip Code: 61603		143.00	
		1.00		2.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		08/29/2019		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		2.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	Y				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 1.00		Part B 2.00		Title V 3.00	
		1.00		2.00		3.00	
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)		N		N		N	
155.00	Hospital	N		N		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	SUBPROVIDER	N		N		158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC	N		N		161.00	
		1.00		2.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name 0		County 1.00		State 2.00	
		1.00		2.00		3.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
		1.00		2.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	
		Beginning 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 5:10 pm
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1310		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part II Date/Time Prepared: 2/27/2020 5:10 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/13/2019	Y	12/13/2019		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		Y		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		Y		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.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		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.		N		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.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	23,473.01	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	23,473.01	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	94.40	0	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	23,567.41	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
26.25 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: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	697	14	965		1.00
2.00	HMO and other (see instructions)	58	0			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	720	0	837		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	151		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,417	14	1,953		7.00
8.00	INTENSIVE CARE UNIT	14	1	17		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,431	15	1,970	0.00	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)	7,376	3,750	20,349	0.00	41.45
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	198.03
28.00	Observation Bed Days		8	337		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: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	228	7	336	1.00
2.00 HMO and other (see instructions)			19	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	228	7	336	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
26.25 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

Health Financial Systems		MENDOTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1310 Component CCN: 14-8535		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/27/2020 5:10 pm		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	1405 E. 12TH ST.				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	MENDOTA		IL	61342	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0
					1.00	
					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
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)					
	CLINIC			08:00	17:00	08:00
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?				Y	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y	2
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number		MENDOTA COMMUNITY HOSPITAL - RHC		148535	14.00
14.01			OSF MEDICAL GROUP WASHINGTON STREET		148567	14.01
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County		LASALLE COUNTY			2.00

MCRIF32 - 15.11.167.3

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/27/2020 5:10 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.402927 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			3,058,618 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?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	10,336,430		6.00
7.00	Medicaid cost (line 1 times line 6)	4,164,827		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)	1,106,209		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)	1,106,209		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)	917,716	190,370	1,108,086 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	369,773	190,370	560,143 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	369,773	190,370	560,143 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,076,030		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	380,390		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	585,215		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,490,815		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	805,515		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,365,658		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,471,867		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		333,781	333,781	135,573	469,354	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS		0	0	256	256	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		479,957	479,957	-88,488	391,469	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,860,416	2,860,416	872,830	3,733,246	4.00
5.01	01140	BUSINESS OFFICE	305	36,046	36,351	0	36,351	5.01
5.02	00550	DATA PROCESSING	0	19,894	19,894	956,320	976,214	5.02
5.03	00570	ADMITTING	0	0	0	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	98,136	126,364	224,500	34,826	259,326	5.04
5.05	00590	OTHER A&G	774,231	5,161,372	5,935,603	-345,296	5,590,307	5.05
7.00	00700	OPERATION OF PLANT	318,985	1,052,500	1,371,485	-209,922	1,161,563	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,252	53,252	0	53,252	8.00
9.00	00900	HOUSEKEEPING	348,685	47,146	395,831	0	395,831	9.00
10.00	01000	DIETARY	266,352	117,651	384,003	-288,172	95,831	10.00
11.00	01100	CAFETERIA	0	0	0	288,172	288,172	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	230,025	2,325	232,350	0	232,350	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	216,975	216,975	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,463,716	83,080	1,546,796	145,956	1,692,752	30.00
31.00	03100	INTENSIVE CARE UNIT	25,066	23,933	48,999	0	48,999	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	376,720	227,096	603,816	-23,097	580,719	50.00
51.00	05100	RECOVERY ROOM	235,776	24,111	259,887	0	259,887	51.00
53.00	05300	ANESTHESIOLOGY	506,559	26,180	532,739	-196	532,543	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	532,330	309,811	842,141	279,369	1,121,510	54.00
56.00	05600	RADIOISOTOPE	4,436	245,175	249,611	-43,382	206,229	56.00
57.00	05700	CT SCAN	164,123	67,746	231,869	-9,590	222,279	57.00
58.00	05800	MRI	106,580	7,978	114,558	0	114,558	58.00
60.00	06000	LABORATORY	664,739	597,200	1,261,939	27,998	1,289,937	60.00
64.00	06400	INTRAVENOUS THERAPY	272,268	21,028	293,296	-3	293,293	64.00
65.00	06500	RESPIRATORY THERAPY	402,368	59,758	462,126	0	462,126	65.00
66.00	06600	PHYSICAL THERAPY	540,524	20,471	560,995	19,447	580,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	86,107	5,333	91,440	5,066	96,506	67.00
68.00	06800	SPEECH PATHOLOGY	63,361	4,494	67,855	4,269	72,124	68.00
69.00	06900	ELECTROCARDIOLOGY	126,527	30,421	156,948	-550	156,398	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-33,927	-33,927	20,506	-13,421	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	224,485	1,822,007	2,046,492	94,450	2,140,942	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	26,196	29,409	55,605	0	55,605	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,014,742	1,928,549	4,943,291	-803,400	4,139,891	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,074,526	2,204,889	3,279,415	0	3,279,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,289,917	1,289,917	-1,289,917	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,947,868	19,285,363	31,233,231	0	31,233,231	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,685	58,685	0	58,685	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,225	21,172	37,397	0	37,397	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	44,792	44,792	0	44,792	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	11,964,093	19,410,012	31,374,105	0	31,374,105	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	17,239	486,593	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	256	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,302,305	1,693,774	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-63,705	3,669,541	4.00
5.01	01140	BUSINESS OFFICE	0	36,351	5.01
5.02	00550	DATA PROCESSING	0	976,214	5.02
5.03	00570	ADMITTING	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	259,326	5.04
5.05	00590	OTHER A&G	-998,464	4,591,843	5.05
7.00	00700	OPERATION OF PLANT	-8,314	1,153,249	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,252	8.00
9.00	00900	HOUSEKEEPING	0	395,831	9.00
10.00	01000	DIETARY	0	95,831	10.00
11.00	01100	CAFETERIA	-86,933	201,239	11.00
13.00	01300	NURSING ADMINISTRATION	169,592	169,592	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,079	229,271	16.00
17.00	01700	SOCIAL SERVICE	-40,042	176,933	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-198,550	1,494,202	30.00
31.00	03100	INTENSIVE CARE UNIT	0	48,999	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	580,719	50.00
51.00	05100	RECOVERY ROOM	0	259,887	51.00
53.00	05300	ANESTHESIOLOGY	-506,559	25,984	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,121,510	54.00
56.00	05600	RADIOISOTOPE	0	206,229	56.00
57.00	05700	CT SCAN	0	222,279	57.00
58.00	05800	MRI	0	114,558	58.00
60.00	06000	LABORATORY	0	1,289,937	60.00
64.00	06400	INTRAVENOUS THERAPY	0	293,293	64.00
65.00	06500	RESPIRATORY THERAPY	0	462,126	65.00
66.00	06600	PHYSICAL THERAPY	0	580,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	96,506	67.00
68.00	06800	SPEECH PATHOLOGY	-24,385	47,739	68.00
69.00	06900	ELECTROCARDIOLOGY	-4,360	152,038	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-13,421	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-752,444	1,388,498	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	-29,409	26,196	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-55,581	4,084,310	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,312,446	1,966,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,595,135	28,638,096	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,685	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37,397	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	0	194.01
194.02	07952	FOUNDATION	0	44,792	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,595,135	28,778,970	200.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 5:10 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS INTEREST EXPENSE					
1.00	OTHER A&G	5.05	0	1,289,917	1.00	
	0		0	1,289,917		
	B - TO RECLASS COPIER LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	19,573	1.00	
2.00		0.00	0	0	2.00	
	0		0	19,573		
	C - TO RECLASS RHC BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	604,641	1.00	
	TOTALS		0	604,641		
	D - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	199,882	88,290	1.00	
	0		199,882	88,290		
	G - TO RECLASS PHY CLNC OFF EQPMT DPR					
1.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	256	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	108,655	2.00	
	0		0	108,911		
	I - TO RECLASS AUTO & OTHER PROP INSUR					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	850	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26,918	2.00	
3.00	OTHER A&G	5.05	0	87,017	3.00	
	0		0	114,785		
	K - TO RECLASS IMPLANTS AND 02 EXP					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	20,506	1.00	
	0		0	20,506		
	L - TO RECLASS DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	56,349	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	
	0		0	56,349		
	V - RHC PHYSICIAN HOSP COSTS					
1.00	ADULTS & PEDIATRICS	30.00	145,956	0	1.00	
	0		145,956	0		
	X - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	52,155	1.00	
	0		0	52,155		
	Y - CLINICAL ENGINEERING DEPT					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	279,406	1.00	
2.00	LABORATORY	60.00	0	46,923	2.00	
	0		0	326,329		
	Z - MINISTRY RECLASS					
1.00	OPERATION OF PLANT	7.00	0	64,252	1.00	
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	38,101	2.00	
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	382,974	3.00	
4.00	PHYSICAL THERAPY	66.00	0	19,447	4.00	
5.00	OCCUPATIONAL THERAPY	67.00	0	5,066	5.00	
6.00	SPEECH PATHOLOGY	68.00	0	4,269	6.00	
7.00	PURCHASING RECEIVING AND STORES	5.04	0	34,826	7.00	
8.00	DATA PROCESSING	5.02	0	956,320	8.00	
9.00	SOCIAL SERVICE	17.00	0	216,975	9.00	
	0		0	1,722,230		
500.00	Grand Total: Increases		345,838	4,403,686	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 5:10 pm

	Decreases						2/27/2020 5:10 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,289,917	0		1.00
	0		0	1,289,917			
	B - TO RECLASS COPIER LEASE EXPENSE						
1.00	LABORATORY	60.00	0	18,925	10		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	648	0		2.00
	0		0	19,573			
	C - TO RECLASS RHC BENEFITS						
1.00	RURAL HEALTH CLINIC	88.00	0	604,641	0		1.00
	TOTALS		0	604,641			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	199,882	88,290	0		1.00
	0		199,882	88,290			
	G - TO RECLASS PHY CLNC OFF EQPMT DPR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	108,911	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	108,911			
	I - TO RECLASS AUTO & OTHER PROP INSUR						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	114,785	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
	0		0	114,785			
	K - TO RECLASS IMPLANTS AND O2 EXP						
1.00	OPERATING ROOM	50.00	0	20,506	0		1.00
	0		0	20,506			
	L - TO RECLASS DRUGS						
1.00	OPERATING ROOM	50.00	0	2,591	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	196	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37	0		3.00
4.00	RADIOISOTOPE	56.00	0	43,382	0		4.00
5.00	CT SCAN	57.00	0	9,590	0		5.00
6.00	INTRAVENOUS THERAPY	64.00	0	3	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	550	0		7.00
	0		0	56,349			
	V - RHC PHYSICIAN HOSP COSTS						
1.00	RURAL HEALTH CLINIC	88.00	145,956	0	0		1.00
	0		145,956	0			
	X - UTILITY EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	52,155	0		1.00
	0		0	52,155			
	Y - CLINICAL ENGINEERING DEPT						
1.00	OPERATION OF PLANT	7.00	0	326,329	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	326,329			
	Z - MINISTRY RECLASS						
1.00	OTHER A&G	5.05	0	1,722,230	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		0	1,722,230			
500.00	Grand Total: Decreases		345,838	4,403,686			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,927,000	0	0	0	0	1.00	
2.00	Land Improvements	2,047,602	0	0	0	0	2.00	
3.00	Buildings and Fixtures	16,266,506	13,685	0	13,685	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	15,174,903	943,190	0	943,190	2,921,938	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	35,416,011	956,875	0	956,875	2,921,938	8.00	
9.00	Reconciling Items	19,232	11,036	0	11,036	0	9.00	
10.00	Total (line 8 minus line 9)	35,396,779	945,839	0	945,839	2,921,938	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,927,000	0				1.00	
2.00	Land Improvements	2,047,602	0				2.00	
3.00	Buildings and Fixtures	16,280,191	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	13,196,155	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	33,450,948	0				8.00	
9.00	Reconciling Items	30,268	0				9.00	
10.00	Total (line 8 minus line 9)	33,420,680	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	333,781	0	0	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	479,957	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	813,738	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	333,781				1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	479,957				2.00
3.00	Total (sum of lines 1-2)	0	813,738				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	20,252,553	0	20,252,553	0.605440	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	2,240	0	2,240	0.000067	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	13,196,155	0	13,196,155	0.394493	0	2.00
3.00	Total (sum of lines 1-2)	33,450,948	0	33,450,948	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	382,761	-8,411	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	256	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,550,658	19,573	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,933,675	11,162	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	85,325	26,918	0	0	486,593	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	256	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	122,693	850	0	0	1,693,774	2.00
3.00	Total (sum of lines 1-2)	208,018	27,768	0	0	2,180,623	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	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-OFFSITE MOBS (chapter 2)			0CAP REL COSTS-OFFSITE MOBS	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-469	OTHER A&G	5.05	11	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)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-8,411	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,046,964			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	521,469			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-85,552	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,079	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	B	-1,381	CAFETERIA	11.00	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-OFFSITE MOBS		0	CAP REL COSTS-OFFSITE MOBS	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-30	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-162	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-8,335	OTHER A&G	5.05	0	33.01
33.02	MISCELLANEOUS INCOME	B	-24,385	SPEECH PATHOLOGY	68.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-4,360	ELECTROCARDIOLOGY	69.00	0	33.03
33.04	340B EXPENSE	A	-752,444	DRUGS CHARGED TO PATIENTS	73.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-51,050	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-11,097	OTHER A&G	5.05	0	33.06
33.07	CABLE TV EXPENSE	A	-8,314	OPERATION OF PLANT	7.00	0	33.07
33.08	INCOME TAXES	A	1,868	OTHER A&G	5.05	0	33.08
33.09	INCOME TAXES	A	-564	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MOB PROPERTY TAXES	A	-20,436	OTHER A&G	5.05	0	33.10
33.11	MOB PROPERTY TAXES	A	-4,531	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	COMMUNITY HEALTH EXPENSE	A	-45,138	OTHER A&G	5.05	0	33.12
33.13	COMMUNITY HEALTH BENEFIT EXPENSE	A	-9,774	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	LOBBYING EXPENSE	A	-14,292	OTHER A&G	5.05	0	33.14
33.15	CRNA BENEFIT EXPENSE	A	-36,510	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	PROVIDER TAX IDPA EXPENSE	A	-818,388	OTHER A&G	5.05	0	33.16
33.17	NON RHC PHYSICIAN BENEFITS	A	-16,695	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	ASSET RE-LIFING	A	99,643	CAP REL COSTS-BLDG & FIXT	1.00	9	33.18
33.19	ASSET RE-LIFING	A	754,246	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,595,135				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: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/27/2020 5:10 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	88,171	247,489	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	425,396	0	2.00
3.00	5.05	OTHER A&G	HO POOLED - ADMIN & GENERAL	1,379,995	2,522,387	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	382,974	382,974	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	259,521	259,521	3.02
3.03	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	279,406	279,406	3.03
3.04	60.00	LABORATORY	MINISTRY ALLOCATION	46,923	46,923	3.04
3.05	31.00	INTENSIVE CARE UNIT	MINISTRY ALLOCATION	2,407	2,407	3.05
3.06	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	19,447	19,447	3.06
3.07	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	5,066	5,066	3.07
3.08	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	4,269	4,269	3.08
3.09	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	111,284	111,284	3.09
3.10	17.00	SOCIAL SERVICE	HO FUNCTIONAL - CARE MANAGEM	176,933	216,975	3.10
3.11	1.00	CAP REL COSTS-BLDG & FIXT	HO INTEREST (OPERATING)	85,325	0	3.11
3.12	2.00	CAP REL COSTS-MVBLE EQUIP	HO INTEREST (OPERATING)	122,693	0	3.12
3.13	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	169,592	0	3.13
3.14	5.05	OTHER A&G	HO FUNCTIONAL - REVENUE CYC	1,919,567	859,430	3.14
4.00	5.05	OTHER A&G	RELATED PARTY SFI	42,335	42,257	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,521,304	4,999,835	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B	0.00	OSF HEALTHCARE	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		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: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/27/2020 5:10 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-159,318	9		1.00
2.00	425,396	9		2.00
3.00	-1,142,392	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	-40,042	0		3.10
3.11	85,325	11		3.11
3.12	122,693	11		3.12
3.13	169,592	0		3.13
3.14	1,060,137	0		3.14
4.00	78	0		4.00
5.00	521,469			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE		6.00
7.00			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: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/27/2020 5:10 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER A&G	70,953	0	70,953	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	198,550	198,550	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	506,559	506,559	0	0	0	3.00
4.00	60.00	LABORATORY	16,620	0	16,620	0	0	4.00
5.00	76.00	CANCER CARE CENTER	29,409	29,409	0	0	0	5.00
6.00	91.00	EMERGENCY	2,065,218	1,312,446	752,772	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,887,309	2,046,964	840,345		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	5.05	OTHER A&G	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	76.00	CANCER CARE CENTER	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	5.05	OTHER A&G	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	198,550		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	506,559		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	76.00	CANCER CARE CENTER	0	0	0	29,409		5.00
6.00	91.00	EMERGENCY	0	0	0	1,312,446		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	2,046,964		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	486,593	486,593			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	256	0	256		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,693,774			1,693,774	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,669,541	686	0	3,672,616	4.00
5.01	01140	BUSINESS OFFICE	36,351	6,474	0	22,537	100 5.01
5.02	00550	DATA PROCESSING	976,214	7,560	0	26,315	0 5.02
5.03	00570	ADMITTING	0	3,992	0	13,895	0 5.03
5.04	00560	PURCHASING RECEIVING AND STORES	259,326	1,772	0	6,168	32,133 5.04
5.05	00590	OTHER A&G	4,591,843	94,764	0	329,865	239,564 5.05
7.00	00700	OPERATION OF PLANT	1,153,249	21,823	0	75,964	104,446 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	53,252	2,307	0	8,032	0 8.00
9.00	00900	HOUSEKEEPING	395,831	5,326	0	18,538	114,171 9.00
10.00	01000	DIETARY	95,831	13,246	0	46,107	21,764 10.00
11.00	01100	CAFETERIA	201,239	5,228	0	18,199	65,448 11.00
13.00	01300	NURSING ADMINISTRATION	169,592	1,728	0	6,015	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	229,271	4,318	0	15,030	75,318 16.00
17.00	01700	SOCIAL SERVICE	176,933	1,456	0	5,067	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,494,202	74,368	0	258,867	462,048 30.00
31.00	03100	INTENSIVE CARE UNIT	48,999	11,264	0	39,210	8,207 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	580,719	21,278	0	74,066	123,351 50.00
51.00	05100	RECOVERY ROOM	259,887	23,873	0	83,098	77,201 51.00
53.00	05300	ANESTHESIOLOGY	25,984	628	0	2,186	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,121,510	18,615	0	64,797	174,302 54.00
56.00	05600	RADIOISOTOPE	206,229	3,344	0	11,641	1,452 56.00
57.00	05700	CT SCAN	222,279	2,254	0	7,845	53,739 57.00
58.00	05800	MRI	114,558	5,048	0	17,572	34,898 58.00
60.00	06000	LABORATORY	1,289,937	9,239	0	32,161	217,657 60.00
64.00	06400	INTRAVENOUS THERAPY	293,293	21,867	0	76,116	89,150 64.00
65.00	06500	RESPIRATORY THERAPY	462,126	10,539	0	36,686	131,749 65.00
66.00	06600	PHYSICAL THERAPY	580,442	10,194	0	35,483	176,985 66.00
67.00	06700	OCCUPATIONAL THERAPY	96,506	1,329	0	4,626	28,194 67.00
68.00	06800	SPEECH PATHOLOGY	47,739	492	0	1,711	20,746 68.00
69.00	06900	ELECTROCARDIOLOGY	152,038	497	0	1,728	41,429 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-13,421	13,616	0	47,395	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,388,498	3,851	0	13,403	73,504 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00	03020	CANCER CARE CENTER	26,196	1,061	0	3,694	8,577 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,084,310	40,847	0	142,184	939,335 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	1,966,969	24,087	0	83,843	351,835 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,638,096	468,971	0	1,632,433	3,667,303 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	58,685	1,178	0	4,101	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,397	15,870	256	55,240	5,313 192.00
194.00	07950	OTHER NRCC	0	0	0	0	0 194.00
194.01	07951	MARKETING	0	287	0	1,000	0 194.01
194.02	07952	FOUNDATION	44,792	287	0	1,000	0 194.02
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	28,778,970	486,593	256	1,693,774	3,672,616 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	
			4A	5.01	5.02	5A.02	5.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	65,462	65,462				5.01
5.02	00550	DATA PROCESSING	1,010,089	2,312	1,012,401			5.02
5.03	00570	ADMITTING	17,887	41	0	17,928	17,928	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	299,399	685	194,661	494,745	381	5.04
5.05	00590	OTHER A&G	5,256,036	12,023	331,991	5,600,050	4,315	5.05
7.00	00700	OPERATION OF PLANT	1,355,482	3,103	493	1,359,078	1,046	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,591	146	0	63,737	49	8.00
9.00	00900	HOUSEKEEPING	533,866	1,222	2,957	538,045	414	9.00
10.00	01000	DIETARY	176,948	405	3,285	180,638	139	10.00
11.00	01100	CAFETERIA	290,114	664	0	290,778	224	11.00
13.00	01300	NURSING ADMINISTRATION	177,335	406	0	177,741	137	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	323,937	741	25,298	349,976	269	16.00
17.00	01700	SOCIAL SERVICE	183,456	420	0	183,876	142	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,289,485	5,241	2,136	2,296,862	1,769	30.00
31.00	03100	INTENSIVE CARE UNIT	107,680	246	8,214	116,140	89	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	799,414	1,830	151,293	952,537	733	50.00
51.00	05100	RECOVERY ROOM	444,059	1,016	18,891	463,966	357	51.00
53.00	05300	ANESTHESIOLOGY	28,798	66	0	28,864	22	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379,224	3,157	30,226	1,412,607	1,088	54.00
56.00	05600	RADIOISOTOPE	222,666	510	0	223,176	172	56.00
57.00	05700	CT SCAN	286,117	655	0	286,772	221	57.00
58.00	05800	MRI	172,076	394	0	172,470	133	58.00
60.00	06000	LABORATORY	1,548,994	3,546	13,470	1,566,010	1,206	60.00
64.00	06400	INTRAVENOUS THERAPY	480,426	1,100	21,684	503,210	387	64.00
65.00	06500	RESPIRATORY THERAPY	641,100	1,467	3,285	645,852	497	65.00
66.00	06600	PHYSICAL THERAPY	803,104	1,838	6,571	811,513	625	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,655	299	0	130,954	101	67.00
68.00	06800	SPEECH PATHOLOGY	70,688	162	0	70,850	55	68.00
69.00	06900	ELECTROCARDIOLOGY	195,692	448	16,427	212,567	164	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,590	109	0	47,699	37	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,479,256	3,386	126,981	1,609,623	1,239	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	39,528	90	0	39,618	31	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,206,676	11,918	37,618	5,256,212	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,426,734	5,555	16,920	2,449,209	1,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,553,564	65,201	1,012,401	28,553,303	17,928	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,964	0	0	63,964	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,076	261	0	114,337	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,287	0	0	1,287	0	194.01
194.02	07952	FOUNDATION	46,079	0	0	46,079	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,778,970	65,462	1,012,401	28,778,970	17,928	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.05	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES	495,126					5.04
5.05	00590	OTHER A&G	15,755	5,620,120	5,620,120			5.05
7.00	00700	OPERATION OF PLANT	24,446	1,384,570	336,003	1,720,573		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,786	15,479	11,359	90,624	8.00
9.00	00900	HOUSEKEEPING	27,026	565,485	137,230	26,216	0	9.00
10.00	01000	DIETARY	2,026	182,803	44,362	65,204	0	10.00
11.00	01100	CAFETERIA	6,093	297,095	72,098	25,737	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	177,878	43,167	8,507	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	635	350,880	85,151	21,256	0	16.00
17.00	01700	SOCIAL SERVICE	0	184,018	44,657	7,165	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,783	2,332,414	566,023	366,088	26,524	30.00
31.00	03100	INTENSIVE CARE UNIT	5,429	121,658	29,524	55,451	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	113,077	1,066,347	258,778	104,744	9,372	50.00
51.00	05100	RECOVERY ROOM	11,133	475,456	115,382	117,517	4,709	51.00
53.00	05300	ANESTHESIOLOGY	10,331	39,217	9,517	3,091	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,689	1,418,384	344,209	91,636	3,419	54.00
56.00	05600	RADIOISOTOPE	1,403	224,751	54,542	16,463	871	56.00
57.00	05700	CT SCAN	33,638	320,631	77,810	11,095	6,522	57.00
58.00	05800	MRI	6,184	178,787	43,387	24,850	1,829	58.00
60.00	06000	LABORATORY	33,162	1,600,378	388,375	45,483	0	60.00
64.00	06400	INTRAVENOUS THERAPY	10,787	514,384	124,829	107,644	0	64.00
65.00	06500	RESPIRATORY THERAPY	30,750	677,099	164,316	51,881	1,094	65.00
66.00	06600	PHYSICAL THERAPY	5,375	817,513	198,392	50,179	7,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	708	131,763	31,976	6,542	943	67.00
68.00	06800	SPEECH PATHOLOGY	0	70,905	17,207	2,420	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,493	217,224	52,715	2,444	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	47,736	11,584	67,026	146	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,114	1,619,976	393,131	18,955	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	39,649	9,622	5,224	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	19,682	5,275,894	1,280,339	201,077	1,239	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	46,311	2,497,406	606,063	118,571	26,486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	456,030	28,514,207	5,555,868	1,633,825	90,624	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,229	100,193	24,315	5,799	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,646	116,983	28,389	78,121	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,287	312	1,414	0	194.01
194.02	07952	FOUNDATION	221	46,300	11,236	1,414	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	495,126	28,778,970	5,620,120	1,720,573	90,624	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	728,931					9.00
10.00	01000	DIETARY	9,102	301,471				10.00
11.00	01100	CAFETERIA	3,603	0	398,533			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	229,552		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,224	0	14,387	0	474,898	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	175,974	269,544	67,817	66,409	150,310	30.00
31.00	03100	INTENSIVE CARE UNIT	16,498	2,591	3,801	3,714	808	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	47,028	0	13,701	13,424	0	50.00
51.00	05100	RECOVERY ROOM	52,717	13,623	10,295	10,077	32,324	51.00
53.00	05300	ANESTHESIOLOGY	0	0	5,412	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,375	0	20,775	20,335	5,926	54.00
56.00	05600	RADIOISOTOPE	6,068	0	132	129	1,616	56.00
57.00	05700	CT SCAN	3,982	0	6,864	6,709	11,314	57.00
58.00	05800	MRI	9,102	0	3,828	3,749	3,232	58.00
60.00	06000	LABORATORY	32,806	0	39,043	38,229	22,088	60.00
64.00	06400	INTRAVENOUS THERAPY	28,634	0	11,457	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,152	0	16,974	0	3,771	65.00
66.00	06600	PHYSICAL THERAPY	26,548	0	20,168	0	10,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,413	0	2,772	0	1,616	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,270	0	808	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,728	5,616	4,041	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,068	0	3,009	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,775	0	6,626	6,482	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	0	1,188	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	118,897	0	85,979	0	33,132	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	78,885	15,713	55,832	54,679	148,692	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)	682,851	301,471	398,058	229,552	430,183	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	46,080	0	475	0	44,715	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	728,931	301,471	398,533	229,552	474,898	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G					5.05
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
17.00	01700	SOCIAL SERVICE	235,840				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	209,837	4,230,940	0	4,230,940	30.00
31.00	03100	INTENSIVE CARE UNIT	0	234,045	0	234,045	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,513,394	0	1,513,394	50.00
51.00	05100	RECOVERY ROOM	0	832,100	0	832,100	51.00
53.00	05300	ANESTHESIOLOGY	0	57,237	0	57,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,938,059	0	1,938,059	54.00
56.00	05600	RADIOISOTOPE	0	304,572	0	304,572	56.00
57.00	05700	CT SCAN	0	444,927	0	444,927	57.00
58.00	05800	MRI	0	268,764	0	268,764	58.00
60.00	06000	LABORATORY	0	2,166,402	0	2,166,402	60.00
64.00	06400	INTRAVENOUS THERAPY	0	786,948	0	786,948	64.00
65.00	06500	RESPIRATORY THERAPY	0	934,287	0	934,287	65.00
66.00	06600	PHYSICAL THERAPY	0	1,130,775	0	1,130,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	179,025	0	179,025	67.00
68.00	06800	SPEECH PATHOLOGY	0	93,610	0	93,610	68.00
69.00	06900	ELECTROCARDIOLOGY	0	287,768	0	287,768	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	135,569	0	135,569	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,052,945	0	2,052,945	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	55,683	0	55,683	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,280	7,006,837	0	7,006,837	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,723	3,618,050	0	3,618,050	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)	235,840	28,271,937	0	28,271,937	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	130,307	0	130,307	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	314,763	0	314,763	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	3,013	0	3,013	194.01
194.02	07952	FOUNDATION	0	58,950	0	58,950	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	235,840	28,778,970	0	28,778,970	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
				0	1.00	1.01		
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	686	0	2,389	3,075	4.00
5.01	01140	BUSINESS OFFICE	0	6,474	0	22,537	29,011	5.01
5.02	00550	DATA PROCESSING	0	7,560	0	26,315	33,875	5.02
5.03	00570	ADMITTING	0	3,992	0	13,895	17,887	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	1,772	0	6,168	7,940	5.04
5.05	00590	OTHER A&G	0	94,764	0	329,865	424,629	5.05
7.00	00700	OPERATION OF PLANT	0	21,823	0	75,964	97,787	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,307	0	8,032	10,339	8.00
9.00	00900	HOUSEKEEPING	0	5,326	0	18,538	23,864	9.00
10.00	01000	DIETARY	0	13,246	0	46,107	59,353	10.00
11.00	01100	CAFETERIA	0	5,228	0	18,199	23,427	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,728	0	6,015	7,743	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,318	0	15,030	19,348	16.00
17.00	01700	SOCIAL SERVICE	0	1,456	0	5,067	6,523	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	74,368	0	258,867	333,235	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,264	0	39,210	50,474	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	21,278	0	74,066	95,344	50.00
51.00	05100	RECOVERY ROOM	0	23,873	0	83,098	106,971	51.00
53.00	05300	ANESTHESIOLOGY	0	628	0	2,186	2,814	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,615	0	64,797	83,412	54.00
56.00	05600	RADIOISOTOPE	0	3,344	0	11,641	14,985	56.00
57.00	05700	CT SCAN	0	2,254	0	7,845	10,099	57.00
58.00	05800	MRI	0	5,048	0	17,572	22,620	58.00
60.00	06000	LABORATORY	0	9,239	0	32,161	41,400	60.00
64.00	06400	INTRAVENOUS THERAPY	0	21,867	0	76,116	97,983	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,539	0	36,686	47,225	65.00
66.00	06600	PHYSICAL THERAPY	0	10,194	0	35,483	45,677	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,329	0	4,626	5,955	67.00
68.00	06800	SPEECH PATHOLOGY	0	492	0	1,711	2,203	68.00
69.00	06900	ELECTROCARDIOLOGY	0	497	0	1,728	2,225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,616	0	47,395	61,011	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,851	0	13,403	17,254	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	1,061	0	3,694	4,755	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	40,847	0	142,184	183,031	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	24,087	0	83,843	107,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	468,971	0	1,632,433	2,101,404	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,178	0	4,101	5,279	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,870	256	55,240	71,366	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	287	0	1,000	1,287	194.01
194.02	07952	FOUNDATION	0	287	0	1,000	1,287	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	486,593	256	1,693,774	2,180,623	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMITTING	PURCHASING RECEIVING AND STORES	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,075					4.00
5.01	01140	BUSINESS OFFICE	0	29,011				5.01
5.02	00550	DATA PROCESSING	0	1,024	34,899			5.02
5.03	00570	ADMITTING	0	18	0	17,905		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	27	304	6,710	380	15,361	5.04
5.05	00590	OTHER A&G	200	5,340	11,446	4,310	489	5.05
7.00	00700	OPERATION OF PLANT	87	1,374	17	1,045	758	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64	0	49	0	8.00
9.00	00900	HOUSEKEEPING	96	541	102	414	838	9.00
10.00	01000	DIETARY	18	179	113	139	63	10.00
11.00	01100	CAFETERIA	55	294	0	224	189	11.00
13.00	01300	NURSING ADMINISTRATION	0	180	0	137	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63	328	872	269	20	16.00
17.00	01700	SOCIAL SERVICE	0	186	0	141	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	387	2,322	74	1,766	1,048	30.00
31.00	03100	INTENSIVE CARE UNIT	7	109	283	89	168	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	103	811	5,215	733	3,507	50.00
51.00	05100	RECOVERY ROOM	65	450	651	357	345	51.00
53.00	05300	ANESTHESIOLOGY	0	29	0	22	321	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146	1,399	1,042	1,086	145	54.00
56.00	05600	RADIOISOTOPE	1	226	0	172	44	56.00
57.00	05700	CT SCAN	45	290	0	221	1,044	57.00
58.00	05800	MRI	29	174	0	133	192	58.00
60.00	06000	LABORATORY	182	1,571	464	1,204	1,029	60.00
64.00	06400	INTRAVENOUS THERAPY	75	487	747	387	335	64.00
65.00	06500	RESPIRATORY THERAPY	110	650	113	497	954	65.00
66.00	06600	PHYSICAL THERAPY	148	814	227	624	167	66.00
67.00	06700	OCCUPATIONAL THERAPY	24	132	0	101	22	67.00
68.00	06800	SPEECH PATHOLOGY	17	72	0	54	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35	198	566	163	139	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	48	0	37	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62	1,500	4,377	1,238	283	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	7	40	0	30	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	788	5,280	1,297	0	611	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	294	2,461	583	1,883	1,437	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)	3,071	28,895	34,899	17,905	14,148	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,124	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4	116	0	0	82	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	7	194.02
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)	3,075	29,011	34,899	17,905	15,361	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.05	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	446,414					5.05
7.00	00700	OPERATION OF PLANT	26,689	127,757				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,230	843	12,525			8.00
9.00	00900	HOUSEKEEPING	10,900	1,947	0	38,702		9.00
10.00	01000	DIETARY	3,524	4,842	0	483	68,714	10.00
11.00	01100	CAFETERIA	5,727	1,911	0	191	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,429	632	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,764	1,578	0	171	0	16.00
17.00	01700	SOCIAL SERVICE	3,547	532	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,960	27,183	3,667	9,344	61,437	30.00
31.00	03100	INTENSIVE CARE UNIT	2,345	4,117	0	876	591	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,555	7,778	1,295	2,497	0	50.00
51.00	05100	RECOVERY ROOM	9,165	8,726	651	2,799	3,105	51.00
53.00	05300	ANESTHESIOLOGY	756	230	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,341	6,804	473	1,772	0	54.00
56.00	05600	RADIOISOTOPE	4,332	1,222	120	322	0	56.00
57.00	05700	CT SCAN	6,180	824	901	211	0	57.00
58.00	05800	MRI	3,446	1,845	253	483	0	58.00
60.00	06000	LABORATORY	30,849	3,377	0	1,742	0	60.00
64.00	06400	INTRAVENOUS THERAPY	9,915	7,993	0	1,520	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,052	3,852	151	1,017	0	65.00
66.00	06600	PHYSICAL THERAPY	15,758	3,726	1,032	1,410	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,540	486	130	181	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,367	180	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,187	181	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	920	4,977	20	322	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,227	1,407	0	413	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	764	388	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	101,702	14,930	171	6,313	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	48,140	8,804	3,661	4,188	3,581	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)	441,311	121,315	12,525	36,255	68,714	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,931	431	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,255	5,801	0	2,447	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	25	105	0	0	0	194.01
194.02	07952	FOUNDATION	892	105	0	0	0	194.02
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)	446,414	127,757	12,525	38,702	68,714	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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	32,018					11.00
13.00	01300	NURSING ADMINISTRATION	0	12,121				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,156	0	30,569			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	10,929		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,448	3,506	9,676	9,724	513,777	30.00
31.00	03100	INTENSIVE CARE UNIT	305	196	52	0	59,612	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,101	709	0	0	139,648	50.00
51.00	05100	RECOVERY ROOM	827	532	2,081	0	136,725	51.00
53.00	05300	ANESTHESIOLOGY	435	0	0	0	4,607	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,669	1,074	381	0	126,744	54.00
56.00	05600	RADIOISOTOPE	11	7	104	0	21,546	56.00
57.00	05700	CT SCAN	551	354	728	0	21,448	57.00
58.00	05800	MRI	308	198	208	0	29,889	58.00
60.00	06000	LABORATORY	3,137	2,019	1,422	0	88,396	60.00
64.00	06400	INTRAVENOUS THERAPY	920	0	0	0	120,362	64.00
65.00	06500	RESPIRATORY THERAPY	1,364	0	243	0	69,228	65.00
66.00	06600	PHYSICAL THERAPY	1,620	0	676	0	71,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	223	0	104	0	9,898	67.00
68.00	06800	SPEECH PATHOLOGY	182	0	52	0	4,127	68.00
69.00	06900	ELECTROCARDIOLOGY	460	297	260	0	8,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	242	0	0	0	67,577	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	532	342	0	0	58,635	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	95	0	0	0	6,079	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,908	0	2,133	476	323,640	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,486	2,887	9,571	729	200,635	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)	31,980	12,121	27,691	10,929	2,083,163	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,765	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38	0	2,878	0	84,987	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	1,417	194.01
194.02	07952	FOUNDATION	0	0	0	0	2,291	194.02
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)	32,018	12,121	30,569	10,929	2,180,623	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01140	BUSINESS OFFICE			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00570	ADMITTING			5.03
5.04	00560	PURCHASING RECEIVING AND STORES			5.04
5.05	00590	OTHER A&G			5.05
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
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	513,777	30.00
31.00	03100	INTENSIVE CARE UNIT	0	59,612	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	139,648	50.00
51.00	05100	RECOVERY ROOM	0	136,725	51.00
53.00	05300	ANESTHESIOLOGY	0	4,607	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	126,744	54.00
56.00	05600	RADIOISOTOPE	0	21,546	56.00
57.00	05700	CT SCAN	0	21,448	57.00
58.00	05800	MRI	0	29,889	58.00
60.00	06000	LABORATORY	0	88,396	60.00
64.00	06400	INTRAVENOUS THERAPY	0	120,362	64.00
65.00	06500	RESPIRATORY THERAPY	0	69,228	65.00
66.00	06600	PHYSICAL THERAPY	0	71,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,898	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,127	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	67,577	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	58,635	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	6,079	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	323,640	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	200,635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,083,163	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,765	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	84,987	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	1,417	194.01
194.02	07952	FOUNDATION	0	2,291	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,180,623	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5A.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,958				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			99,958		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141	0	141	11,216,395	4.00
5.01	01140	BUSINESS OFFICE	1,330	0	1,330	305	-65,462
5.02	00550	DATA PROCESSING	1,553	0	1,553	0	0
5.03	00570	ADMITTING	820	0	820	0	0
5.04	00560	PURCHASING RECEIVING AND STORES	364	0	364	98,136	0
5.05	00590	OTHER A&G	19,467	0	19,467	731,642	0
7.00	00700	OPERATION OF PLANT	4,483	0	4,483	318,985	0
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	474	0	0
9.00	00900	HOUSEKEEPING	1,094	0	1,094	348,685	0
10.00	01000	DIETARY	2,721	0	2,721	66,470	0
11.00	01100	CAFETERIA	1,074	0	1,074	199,882	0
13.00	01300	NURSING ADMINISTRATION	355	0	355	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	887	230,025	0
17.00	01700	SOCIAL SERVICE	299	0	299	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,277	0	15,277	1,411,122	0
31.00	03100	INTENSIVE CARE UNIT	2,314	0	2,314	25,066	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,371	0	4,371	376,720	0
51.00	05100	RECOVERY ROOM	4,904	0	4,904	235,776	0
53.00	05300	ANESTHESIOLOGY	129	0	129	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824	0	3,824	532,330	0
56.00	05600	RADIOISOTOPE	687	0	687	4,436	0
57.00	05700	CT SCAN	463	0	463	164,123	0
58.00	05800	MRI	1,037	0	1,037	106,580	0
60.00	06000	LABORATORY	1,898	0	1,898	664,739	0
64.00	06400	INTRAVENOUS THERAPY	4,492	0	4,492	272,268	0
65.00	06500	RESPIRATORY THERAPY	2,165	0	2,165	402,368	0
66.00	06600	PHYSICAL THERAPY	2,094	0	2,094	540,524	0
67.00	06700	OCCUPATIONAL THERAPY	273	0	273	86,107	0
68.00	06800	SPEECH PATHOLOGY	101	0	101	63,361	0
69.00	06900	ELECTROCARDIOLOGY	102	0	102	126,527	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,797	0	2,797	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	791	224,485	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	03020	CANCER CARE CENTER	218	0	218	26,196	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,391	0	8,391	2,868,786	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	4,948	0	4,948	1,074,526	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,338	0	96,338	11,200,170	-65,462
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	0	242	0	-63,964
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,260	100	3,260	16,225	0
194.00	07950	OTHER NRCC	0	0	0	0	0
194.01	07951	MARKETING	59	0	59	0	-1,287
194.02	07952	FOUNDATION	59	0	59	0	-46,079
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)	486,593	256	1,693,774	3,672,616	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.867975	2.560000	16.944857	0.327433	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				3,075	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000274	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: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HO URS)	Reconciliatio n	ADMITTING (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			5.01	5.02	5A.03	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	28,602,178					5.01
5.02	00550	DATA PROCESSING	1,010,089	6,163				5.02
5.03	00570	ADMITTING	17,887	0	-17,928	23,279,163		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	299,399	1,185	0	494,745	787,107	5.04
5.05	00590	OTHER A&G	5,256,036	2,021	0	5,600,050	25,046	5.05
7.00	00700	OPERATION OF PLANT	1,355,482	3	0	1,359,078	38,862	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,591	0	0	63,737	0	8.00
9.00	00900	HOUSEKEEPING	533,866	18	0	538,045	42,963	9.00
10.00	01000	DIETARY	176,948	20	0	180,638	3,221	10.00
11.00	01100	CAFETERIA	290,114	0	0	290,778	9,686	11.00
13.00	01300	NURSING ADMINISTRATION	177,335	0	0	177,741	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	323,937	154	0	349,976	1,009	16.00
17.00	01700	SOCIAL SERVICE	183,456	0	0	183,876	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,289,485	13	0	2,296,862	53,705	30.00
31.00	03100	INTENSIVE CARE UNIT	107,680	50	0	116,140	8,631	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	799,414	921	0	952,537	179,761	50.00
51.00	05100	RECOVERY ROOM	444,059	115	0	463,966	17,699	51.00
53.00	05300	ANESTHESIOLOGY	28,798	0	0	28,864	16,424	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379,224	184	0	1,412,607	7,454	54.00
56.00	05600	RADIOISOTOPE	222,666	0	0	223,176	2,230	56.00
57.00	05700	CT SCAN	286,117	0	0	286,772	53,475	57.00
58.00	05800	MRI	172,076	0	0	172,470	9,830	58.00
60.00	06000	LABORATORY	1,548,994	82	0	1,566,010	52,718	60.00
64.00	06400	INTRAVENOUS THERAPY	480,426	132	0	503,210	17,149	64.00
65.00	06500	RESPIRATORY THERAPY	641,100	20	0	645,852	48,883	65.00
66.00	06600	PHYSICAL THERAPY	803,104	40	0	811,513	8,545	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,655	0	0	130,954	1,126	67.00
68.00	06800	SPEECH PATHOLOGY	70,688	0	0	70,850	0	68.00
69.00	06900	ELECTROCARDIOLOGY	195,692	100	0	212,567	7,143	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,590	0	0	47,699	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,479,256	773	0	1,609,623	14,488	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	39,528	0	0	39,618	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,206,676	229	-5,256,212	0	31,288	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,426,734	103	0	2,449,209	73,621	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)	28,488,102	6,163	-5,274,140	23,279,163	724,957	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-63,964	0	57,593	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,076	0	-114,337	0	4,206	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	-1,287	0	0	194.01
194.02	07952	FOUNDATION	0	0	-46,079	0	351	194.02
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)	65,462	1,012,401		17,928	495,126	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.002289	164.270810		0.000770	0.629045	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,011	34,899		17,905	15,361	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001014	5.662664		0.000769	0.019516	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: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A.05	5.05	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G	-5,620,120	23,158,850			5.05
7.00	00700	OPERATION OF PLANT	0	1,384,570	71,800		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,786	474	86,066	8.00
9.00	00900	HOUSEKEEPING	0	565,485	1,094	0	9.00
10.00	01000	DIETARY	0	182,803	2,721	0	10.00
11.00	01100	CAFETERIA	0	297,095	1,074	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	177,878	355	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	350,880	887	0	16.00
17.00	01700	SOCIAL SERVICE	0	184,018	299	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,332,414	15,277	25,189	30.00
31.00	03100	INTENSIVE CARE UNIT	0	121,658	2,314	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,066,347	4,371	8,901	50.00
51.00	05100	RECOVERY ROOM	0	475,456	4,904	4,472	51.00
53.00	05300	ANESTHESIOLOGY	0	39,217	129	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,418,384	3,824	3,247	54.00
56.00	05600	RADIOISOTOPE	0	224,751	687	827	56.00
57.00	05700	CT SCAN	0	320,631	463	6,194	57.00
58.00	05800	MRI	0	178,787	1,037	1,737	58.00
60.00	06000	LABORATORY	0	1,600,378	1,898	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	514,384	4,492	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	677,099	2,165	1,039	65.00
66.00	06600	PHYSICAL THERAPY	0	817,513	2,094	7,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	131,763	273	896	67.00
68.00	06800	SPEECH PATHOLOGY	0	70,905	101	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	217,224	102	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	47,736	2,797	139	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,619,976	791	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	39,649	218	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,275,894	8,391	1,177	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,497,406	4,948	25,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,620,120	22,894,087	68,180	86,066	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	100,193	242	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	116,983	3,260	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,287	59	0	194.01
194.02	07952	FOUNDATION	0	46,300	59	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		5,620,120	1,720,573	90,624	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.242677	23.963412	1.052959	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		446,414	127,757	12,525	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.019276	1.779345	0.145528	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: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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	7,214					10.00
11.00	01100	CAFETERIA	0	15,097				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	184,721			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	545	0	1,763		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	390	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,450	2,569	53,439	558	347	30.00
31.00	03100	INTENSIVE CARE UNIT	62	144	2,989	3	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	519	10,802	0	0	50.00
51.00	05100	RECOVERY ROOM	326	390	8,109	120	0	51.00
53.00	05300	ANESTHESIOLOGY	0	205	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	787	16,364	22	0	54.00
56.00	05600	RADIOISOTOPE	0	5	104	6	0	56.00
57.00	05700	CT SCAN	0	260	5,399	42	0	57.00
58.00	05800	MRI	0	145	3,017	12	0	58.00
60.00	06000	LABORATORY	0	1,479	30,763	82	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	434	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	643	0	14	0	65.00
66.00	06600	PHYSICAL THERAPY	0	764	0	39	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	105	0	6	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	86	0	3	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	217	4,519	15	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	114	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	251	5,216	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	45	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,257	0	123	17	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	376	2,115	44,000	552	26	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)	7,214	15,079	184,721	1,597	390	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	18	0	166	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	301,471	398,533	229,552	474,898	235,840	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.789714	26.398159	1.242696	269.369257	604.717949	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,714	32,018	12,121	30,569	10,929	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.525090	2.120819	0.065618	17.339195	28.023077	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,230,940		4,230,940	0
31.00	03100	INTENSIVE CARE UNIT	234,045		234,045	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,513,394		1,513,394	0
51.00	05100	RECOVERY ROOM	832,100		832,100	0
53.00	05300	ANESTHESIOLOGY	57,237		57,237	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,938,059		1,938,059	0
56.00	05600	RADIOISOTOPE	304,572		304,572	0
57.00	05700	CT SCAN	444,927		444,927	0
58.00	05800	MRI	268,764		268,764	0
60.00	06000	LABORATORY	2,166,402		2,166,402	0
64.00	06400	INTRAVENOUS THERAPY	786,948		786,948	0
65.00	06500	RESPIRATORY THERAPY	934,287	0	934,287	0
66.00	06600	PHYSICAL THERAPY	1,130,775	0	1,130,775	0
67.00	06700	OCCUPATIONAL THERAPY	179,025	0	179,025	0
68.00	06800	SPEECH PATHOLOGY	93,610	0	93,610	0
69.00	06900	ELECTROCARDIOLOGY	287,768		287,768	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	135,569		135,569	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,052,945		2,052,945	0
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0
76.00	03020	CANCER CARE CENTER	55,683		55,683	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,006,837		7,006,837	0
90.00	09000	CLINIC	0		0	0
91.00	09100	EMERGENCY	3,618,050		3,618,050	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	662,795		662,795	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	28,934,732	0	28,934,732	0
201.00		Less Observation Beds	662,795		662,795	0
202.00		Total (see instructions)	28,271,937	0	28,271,937	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

			Title XVIII			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,504,624		2,504,624			30.00	
31.00	03100	INTENSIVE CARE UNIT	68,692		68,692			31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	309,295	4,203,713	4,513,008	0.335340	0.000000	50.00	
51.00	05100	RECOVERY ROOM	13,884	930,467	944,351	0.881134	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	177,338	1,731,454	1,908,792	0.029986	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,028	5,048,870	5,242,898	0.369654	0.000000	54.00	
56.00	05600	RADIOISOTOPE	26,974	1,303,217	1,330,191	0.228969	0.000000	56.00	
57.00	05700	CT SCAN	385,784	8,765,504	9,151,288	0.048619	0.000000	57.00	
58.00	05800	MRI	78,998	2,681,344	2,760,342	0.097366	0.000000	58.00	
60.00	06000	LABORATORY	1,021,617	11,424,396	12,446,013	0.174064	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	689,723	689,723	1.140962	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	790,701	707,875	1,498,576	0.623450	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	296,252	3,336,979	3,633,231	0.311231	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	29,754	424,526	454,280	0.394085	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	13,039	206,172	219,211	0.427031	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	279,228	3,604,890	3,884,118	0.074088	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,759	200,773	248,532	0.545479	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,386,254	5,326,055	6,712,309	0.305848	0.000000	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00	
76.00	03020	CANCER CARE CENTER	0	71,971	71,971	0.773687	0.000000	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,819,712	5,819,712			88.00	
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
91.00	09100	EMERGENCY	142,113	5,338,561	5,480,674	0.660147	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	45,048	538,757	583,805	1.135302	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	7,811,382	62,354,959	70,166,341			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	7,811,382	62,354,959	70,166,341			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03020	CANCER CARE CENTER	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	139,648	4,513,008	0.030943	137,147	4,244
51.00	05100	RECOVERY ROOM	136,725	944,351	0.144782	3,690	534
53.00	05300	ANESTHESIOLOGY	4,607	1,908,792	0.002414	75,472	182
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,744	5,242,898	0.024174	109,084	2,637
56.00	05600	RADIOISOTOPE	21,546	1,330,191	0.016198	19,266	312
57.00	05700	CT SCAN	21,448	9,151,288	0.002344	133,737	313
58.00	05800	MRI	29,889	2,760,342	0.010828	35,705	387
60.00	06000	LABORATORY	88,396	12,446,013	0.007102	447,484	3,178
64.00	06400	INTRAVENOUS THERAPY	120,362	689,723	0.174508	0	0
65.00	06500	RESPIRATORY THERAPY	69,228	1,498,576	0.046196	356,092	16,450
66.00	06600	PHYSICAL THERAPY	71,879	3,633,231	0.019784	39,451	780
67.00	06700	OCCUPATIONAL THERAPY	9,898	454,280	0.021788	2,610	57
68.00	06800	SPEECH PATHOLOGY	4,127	219,211	0.018827	3,591	68
69.00	06900	ELECTROCARDIOLOGY	8,711	3,884,118	0.002243	133,396	299
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	67,577	248,532	0.271905	23,611	6,420
73.00	07300	DRUGS CHARGED TO PATIENTS	58,635	6,712,309	0.008735	506,244	4,422
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0
76.00	03020	CANCER CARE CENTER	6,079	71,971	0.084465	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	323,640	5,819,712	0.055611	0	0
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	200,635	5,480,674	0.036608	42,662	1,562
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	80,485	583,805	0.137863	0	0
200.00		Total (lines 50 through 199)	1,590,259	67,593,025		2,069,242	41,845

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 5:10 pm

				Title XVIII		Hospital	Cost			
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
				4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	4,513,008	0.000000	50.00	
51.00	05100	RECOVERY ROOM		0	0	0	944,351	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY		0	0	0	1,908,792	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	5,242,898	0.000000	54.00	
56.00	05600	RADIOISOTOPE		0	0	0	1,330,191	0.000000	56.00	
57.00	05700	CT SCAN		0	0	0	9,151,288	0.000000	57.00	
58.00	05800	MRI		0	0	0	2,760,342	0.000000	58.00	
60.00	06000	LABORATORY		0	0	0	12,446,013	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY		0	0	0	689,723	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY		0	0	0	1,498,576	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY		0	0	0	3,633,231	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	454,280	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY		0	0	0	219,211	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY		0	0	0	3,884,118	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	248,532	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	6,712,309	0.000000	73.00	
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00	
76.00	03020	CANCER CARE CENTER		0	0	0	71,971	0.000000	76.00	
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	5,819,712	0.000000	88.00	
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00	
91.00	09100	EMERGENCY		0	0	0	5,480,674	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	583,805	0.000000	92.00	
200.00		Total (lines 50 through 199)		0	0	0	67,593,025		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 5:10 pm

				Title XVIII		Hospital	Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0.000000	137,147	0	0	0
51.00	05100	RECOVERY ROOM		0.000000	3,690	0	0	0
53.00	05300	ANESTHESIOLOGY		0.000000	75,472	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	109,084	0	0	0
56.00	05600	RADIOISOTOPE		0.000000	19,266	0	0	0
57.00	05700	CT SCAN		0.000000	133,737	0	0	0
58.00	05800	MRI		0.000000	35,705	0	0	0
60.00	06000	LABORATORY		0.000000	447,484	0	0	0
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY		0.000000	356,092	0	0	0
66.00	06600	PHYSICAL THERAPY		0.000000	39,451	0	0	0
67.00	06700	OCCUPATIONAL THERAPY		0.000000	2,610	0	0	0
68.00	06800	SPEECH PATHOLOGY		0.000000	3,591	0	0	0
69.00	06900	ELECTROCARDIOLOGY		0.000000	133,396	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	23,611	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	506,244	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	0	0
76.00	03020	CANCER CARE CENTER		0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0
90.00	09000	CLINIC		0.000000	0	0	0	0
91.00	09100	EMERGENCY		0.000000	42,662	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0
200.00		Total (lines 50 through 199)			2,069,242	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 5:10 pm

			Title XVIII		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.335340	0	1,734,408	0		0	50.00
51.00	05100	RECOVERY ROOM	0.881134	0	378,014	0		0	51.00
53.00	05300	ANESTHESIOLOGY	0.029986	0	657,733	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.369654	0	1,676,565	0		0	54.00
56.00	05600	RADIOISOTOPE	0.228969	0	623,545	0		0	56.00
57.00	05700	CT SCAN	0.048619	0	3,886,516	0		0	57.00
58.00	05800	MRI	0.097366	0	1,011,364	0		0	58.00
60.00	06000	LABORATORY	0.174064	0	4,596,293	0		0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.140962	0	495,649	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	0.623450	0	342,590	0		0	65.00
66.00	06600	PHYSICAL THERAPY	0.311231	0	1,225,748	0		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.394085	0	69,451	0		0	67.00
68.00	06800	SPEECH PATHOLOGY	0.427031	0	45,305	0		0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074088	0	1,719,876	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.545479	0	79,804	0		0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305848	0	2,987,432	7,715		0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0		0	75.00
76.00	03020	CANCER CARE CENTER	0.773687	0	40,566	0		0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000					0	88.00
90.00	09000	CLINIC	0.000000	0	0	0		0	90.00
91.00	09100	EMERGENCY	0.660147	0	1,846,689	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.135302	0	286,835	0		0	92.00
200.00		Subtotal (see instructions)		0	23,704,383	7,715		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	23,704,383	7,715		0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1310		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part V Date/Time Prepared: 2/27/2020 5:10 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				Costs					
				Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
				6.00	7.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	581,616	0					50.00
51.00	05100	RECOVERY ROOM	333,081	0					51.00
53.00	05300	ANESTHESIOLOGY	19,723	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,749	0					54.00
56.00	05600	RADIOISOTOPE	142,772	0					56.00
57.00	05700	CT SCAN	188,959	0					57.00
58.00	05800	MRI	98,472	0					58.00
60.00	06000	LABORATORY	800,049	0					60.00
64.00	06400	INTRAVENOUS THERAPY	565,517	0					64.00
65.00	06500	RESPIRATORY THERAPY	213,588	0					65.00
66.00	06600	PHYSICAL THERAPY	381,491	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	27,370	0					67.00
68.00	06800	SPEECH PATHOLOGY	19,347	0					68.00
69.00	06900	ELECTROCARDIOLOGY	127,422	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,531	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	913,700	2,360					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
76.00	03020	CANCER CARE CENTER	31,385	0					76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	1,219,086	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	325,644	0					92.00
200.00		Subtotal (see instructions)	6,652,502	2,360					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	6,652,502	2,360					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1310

Period:

Worksheet D

Component CCN:14-Z310

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 5:10 pm

			Title XVIII	Swing Beds - SNF	Cost			
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.335340	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.881134	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.029986	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.369654	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.228969	0	0	0	0	56.00
57.00	05700	CT SCAN	0.048619	0	0	0	0	57.00
58.00	05800	MRI	0.097366	0	0	0	0	58.00
60.00	06000	LABORATORY	0.174064	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.140962	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.623450	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.311231	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.394085	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.427031	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074088	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.545479	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305848	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0.773687	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.660147	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.135302	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1310

Period:

Worksheet D

Component CCN:14-Z310

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 5:10 pm

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
76.00	03020	CANCER CARE CENTER	0	0					76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 5:10 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,290	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,302	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)		965	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		209	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)		628	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		38	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)		113	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		697	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)		180	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)		540	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		159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,230,940	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)		5,973	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)		18,077	25.00
26.00	Total swing-bed cost (see instructions)		1,670,228	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,560,712	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,560,712	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)		1,966.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,370,832	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,370,832	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	234,045	17	13,767.35	14	192,743	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)					626,713	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,190,288	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)					354,017	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,062,050	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,416,067	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)					337	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,966.75	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					662,795	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/27/2020 5:10 pm	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	513,777	4,230,940	0.121433	662,795	80,485	90.00
91.00	Nursing School cost	0	4,230,940	0.000000	662,795	0	91.00
92.00	Allied health cost	0	4,230,940	0.000000	662,795	0	92.00
93.00	All other Medical Education	0	4,230,940	0.000000	662,795	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 5:10 pm	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		739,768		30.00
31.00	03100	INTENSIVE CARE UNIT		27,762		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.335340	137,147	45,991	50.00
51.00	05100	RECOVERY ROOM	0.881134	3,690	3,251	51.00
53.00	05300	ANESTHESIOLOGY	0.029986	75,472	2,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.369654	109,084	40,323	54.00
56.00	05600	RADIOISOTOPE	0.228969	19,266	4,411	56.00
57.00	05700	CT SCAN	0.048619	133,737	6,502	57.00
58.00	05800	MRI	0.097366	35,705	3,476	58.00
60.00	06000	LABORATORY	0.174064	447,484	77,891	60.00
64.00	06400	INTRAVENOUS THERAPY	1.140962	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.623450	356,092	222,006	65.00
66.00	06600	PHYSICAL THERAPY	0.311231	39,451	12,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.394085	2,610	1,029	67.00
68.00	06800	SPEECH PATHOLOGY	0.427031	3,591	1,533	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074088	133,396	9,883	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.545479	23,611	12,879	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305848	506,244	154,834	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03020	CANCER CARE CENTER	0.773687	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.660147	42,662	28,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.135302	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,069,242	626,713	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)		2,069,242		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3
			Component CCN: 14-Z310		Date/Time Prepared: 2/27/2020 5:10 pm
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.335340	3,014	1,011
51.00	05100	RECOVERY ROOM	0.881134	0	0
53.00	05300	ANESTHESIOLOGY	0.029986	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.369654	23,856	8,818
56.00	05600	RADIOISOTOPE	0.228969	0	0
57.00	05700	CT SCAN	0.048619	45,171	2,196
58.00	05800	MRI	0.097366	0	0
60.00	06000	LABORATORY	0.174064	181,121	31,527
64.00	06400	INTRAVENOUS THERAPY	1.140962	0	0
65.00	06500	RESPIRATORY THERAPY	0.623450	230,346	143,609
66.00	06600	PHYSICAL THERAPY	0.311231	196,405	61,127
67.00	06700	OCCUPATIONAL THERAPY	0.394085	22,294	8,786
68.00	06800	SPEECH PATHOLOGY	0.427031	9,448	4,035
69.00	06900	ELECTROCARDIOLOGY	0.074088	5,124	380
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.545479	6,644	3,624
73.00	07300	DRUGS CHARGED TO PATIENTS	0.305848	311,447	95,255
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0
76.00	03020	CANCER CARE CENTER	0.773687	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0
90.00	09000	CLINIC	0.000000	0	0
91.00	09100	EMERGENCY	0.660147	2,073	1,368
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.135302	0	0
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,036,943	361,736
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		1,036,943	361,736

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 5:10 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,654,862	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6,654,862	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		6,721,411	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)		40,950	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,835,127	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)		2,845,334	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)		2,845,334	30.00
31.00	Primary payer payments		304	31.00
32.00	Subtotal (line 30 minus line 31)		2,845,030	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)		543,044	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		352,979	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		430,912	36.00
37.00	Subtotal (see instructions)		3,198,009	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)		3,198,009	40.00
40.01	Sequestration adjustment (see instructions)		63,960	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,895,480	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-761,431	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/27/2020 5:10 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,913,723		3,837,743	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	05/02/2019	57,737	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	05/02/2019	73,854		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)		-73,854		57,737	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,839,869		3,895,480	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		130,141		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		761,431	6.02
7.00	Total Medicare program liability (see instructions)		1,970,010		3,134,049	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: 14-1310

Period:

Worksheet E-1

Component CCN: 14-Z310

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 5:10 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,655,895		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	05/02/2019	26,260		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)		-26,260		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,629,635		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		112,748		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,742,383		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: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/27/2020 5:10 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			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: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet E-2	
		Component CCN: 14-Z310		Date/Time Prepared: 2/27/2020 5:10 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,430,228	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		365,353	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		720	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,795,581	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,795,581	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,795,581	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		17,639	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,777,942	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,777,942	0	19.00
19.01	Sequestration adjustment (see instructions)		35,559	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,629,635	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		112,748	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1310	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/27/2020 5:10 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,190,288	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,190,288	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,212,191	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,212,191	19.00
20.00	Deductibles (exclude professional component)		229,388	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,982,803	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,982,803	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		42,171	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		27,411	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		33,762	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,010,214	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,010,214	30.00
30.01	Sequestration adjustment (see instructions)		40,204	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,839,869	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		130,141	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/27/2020 5:10 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,319,799	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	9,955,861	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,900,737	0	0	0	6.00
7.00	Inventory	670,364	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	106,028	0	0	0	9.00
10.00	Due from other funds	11,494	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,162,809	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,927,000	0	0	0	12.00
13.00	Land improvements	2,047,602	0	0	0	13.00
14.00	Accumulated depreciation	-1,677,710	0	0	0	14.00
15.00	Buildings	16,249,923	0	0	0	15.00
16.00	Accumulated depreciation	-7,334,343	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	13,196,155	0	0	0	23.00
24.00	Accumulated depreciation	-10,283,747	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	30,268	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,155,148	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	137,723	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	12,618,475	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,756,198	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,074,155	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	515,082	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,067,918	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	646,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,031,018	0	0	0	43.00
44.00	Other current liabilities	40,903	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,300,921	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	25,974,534	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	25,974,534	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	29,275,455	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,798,700				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	3,798,700	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,074,155	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/27/2020 5:10 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,283,113		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,522,954				2.00
3.00	Total (sum of line 1 and line 2)		3,806,067		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)		3,806,067		0		11.00
12.00	ROUNDING/EQUITY TRANSFER	7,367		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)		7,367		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,798,700		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	ROUNDING/EQUITY TRANSFER		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: 14-1310

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2020 5:10 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,626,292		1,626,292	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	744,093		744,093	5.00
6.00	Swing bed - NF	134,239		134,239	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,504,624		2,504,624	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	68,692		68,692	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)	68,692		68,692	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,573,316		2,573,316	17.00
18.00	Ancillary services	5,050,905	50,657,929	55,708,834	18.00
19.00	Outpatient services	187,161	5,877,318	6,064,479	19.00
20.00	RURAL HEALTH CLINIC	0	5,819,712	5,819,712	20.00
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	PRO FEES	142,336	3,249,832	3,392,168	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,953,718	65,604,791	73,558,509	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,374,105		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)		31,374,105		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/27/2020 5:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	73,558,509	1.00
2.00	Less contractual allowances and discounts on patients' accounts	40,984,499	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,574,010	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,374,105	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,199,905	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	59,791	6.00
7.00	Income from investments	467	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	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	85,552	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	1,540,891	17.00
18.00	Revenue from sale of medical records and abstracts	3,079	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	385	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	70,036	20.00
21.00	Rental of vending machines	1,381	21.00
22.00	Rental of hospital space	8,411	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	151,886	24.00
25.00	Total other income (sum of lines 6-24)	1,921,879	25.00
26.00	Total (line 5 plus line 25)	3,121,784	26.00
27.00	EQUITY TRANSFER	598,830	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	598,830	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,522,954	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 5:10 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	1,191,125	0	1,191,125	-145,956	1,045,169
2.00	Physician Assistant	175,458	0	175,458	0	175,458
3.00	Nurse Practitioner	390,108	0	390,108	0	390,108
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	565,867	0	565,867	0	565,867
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	50,648	0	50,648	0	50,648
10.00	Subtotal (sum of lines 1 through 9)	2,373,206	0	2,373,206	-145,956	2,227,250
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	275,336	275,336	0	275,336
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	33,648	33,648	0	33,648
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	308,984	308,984	0	308,984
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,373,206	308,984	2,682,190	-145,956	2,536,234
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	74,180	74,180	-52,155	22,025
30.00	Administrative Costs	641,536	1,545,385	2,186,921	-605,289	1,581,632
31.00	Total Facility Overhead (sum of lines 29 and 30)	641,536	1,619,565	2,261,101	-657,444	1,603,657
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,014,742	1,928,549	4,943,291	-803,400	4,139,891

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 5:10 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,045,169	1.00
2.00	Physician Assistant	0	175,458	2.00
3.00	Nurse Practitioner	0	390,108	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	565,867	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	50,648	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,227,250	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	275,336	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	33,648	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	308,984	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,536,234	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	22,025	29.00
30.00	Administrative Costs	-55,581	1,526,051	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-55,581	1,548,076	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-55,581	4,084,310	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1310

Period:

Worksheet M-2

Component CCN: 14-8535

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 5:10 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	3.08	11,142	3,990	12,289	1.00
2.00	Physician Assistant	1.07	2,872	2,100	2,247	2.00
3.00	Nurse Practitioner	2.83	6,335	2,100	5,943	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.98	20,349		20,479	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)	6.98	20,349		20,479	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)				2,536,234	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)				2,536,234	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)				1,548,076	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,922,527	15.00
16.00	Total overhead (sum of lines 14 and 15)				4,470,603	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				4,470,603	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				4,470,603	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				7,006,837	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1310 Component CCN:14-8535	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/27/2020 5:10 pm		
			Title XVIII	RHC I	Cost	
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			7,006,837	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			521,469	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,485,368	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,479	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)			20,479	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			316.68	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			316.68	316.68	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			1,844	5,532	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			583,958	1,751,874	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	2,335,832	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,612,540	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				4,664	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				6,755	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				1,746,463	16.04
16.05	Total program cost (see instructions)			0	1,753,218	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				145,998	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				292,376	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				1,753,218	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				214,891	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				1,968,109	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				1,968,109	26.00
26.01	Sequestration adjustment (see instructions)				39,362	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,543,278	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)				385,469	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: 14-1310 Component CCN: 14-8535	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 5:10 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,227,250	2,227,250	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003872	0.009335	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		8,624	20,791	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		104,920	54,419	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		113,544	75,210	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,536,234	2,536,234	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,470,603	4,470,603	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.044769	0.029654	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		200,144	132,571	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		313,688	207,781	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		805	1,941	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		389.67	107.05	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		399	555	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		155,478	59,413	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)			521,469	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)			214,891	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 5:10 pm	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			1,755,299	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			05/02/2019	212,021	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)			-212,021	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			1,543,278	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			385,469	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			1,928,747	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
			1.00	2.00	
8.00	Name of Contractor				8.00