

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/27/2020 10:33 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/27/2020	Time: 10:33 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BCC DBA ILLINI COMMUNITY HOSPITAL (14-1315) 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) TIMOTHY MOORE
Officer or Administrator of Provider(s)

VP-FINANCE, CAO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	109,180	297,476	0	0	1.00
2.00	Subprovider - IPF	0	53,135	29		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	25,191	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-63,520		0	10.00
200.00	Total	0	187,506	233,985	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: 14-1315		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 10:33 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 640 WEST WASHINGTON			PO Box:				1.00		
2.00	City: PITTSFIELD			State: IL		Zip Code: 62363		County:		
		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		BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	1	09/01/2001	N	O	N
4.00	Subprovider - IPF		BCC DBA ILLINI COMM HOSP GERIPSYCH	14M315	99914	4	10/01/2015	N	P	N
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		BCC DBA ILLINI COMM HOSP-SWINGBED	14Z315	99914		09/01/2001	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		BCC DBA ILLINI COMM HOSPORHC	143482	99914		07/03/2006	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)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim 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.						0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1315

Period:
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To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/27/2020 10:33 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	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 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.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/27/2020 10:33 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	
		1.00	2.00	3.00	4.00
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
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)				0.00
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)				
61.03	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)				
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).				
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)				
61.06	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)				
		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
61.20	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
					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
62.01	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
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
		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

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

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				1.00				
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	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.			N	N	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.			N	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.			N	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.			N	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.			N	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)			N		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			Y	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

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	79,500	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					
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		14H132	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1315		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 10:33 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: BLESSING CORPORATE SERVICES		Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131		141.00		
142.00	Street: BROADWAY AT 11TH STREET		PO Box:				142.00		
143.00	City: QUINCY		State: IL		Zip Code: 62301		143.00		
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N	155.00	
156.00	Subprovider - IPF			N	N	N	N	156.00	
157.00	Subprovider - IRF			N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF			N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N	160.00	
161.00	CMHC				N	N	N	161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/27/2020 10:33 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/31/2020	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/27/2020 10:33 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		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.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CONNIE.ZIEGLER@BLESSINGHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/27/2020 10:33 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.	REIMBURSEMENT COORDINATOR	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: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 10:33 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	17,544.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	17,544.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	17,544.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	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 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		35			0	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: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 10:33 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)	502	29	725			1.00
2.00 HMO and other (see instructions)	97	45				2.00
3.00 HMO IPF Subprovider	179	263				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	290	0	290			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	72			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	792	29	1,087			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)	792	29	1,087	0.00	145.18	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	774	49	1,523	0.00	17.45	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 RURAL HEALTH CLINIC	2,599	0	9,739	0.00	14.45	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	177.08	27.00
28.00 Observation Bed Days		0	130			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			6			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: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 10:33 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	172	13	254	1.00
2.00 HMO and other (see instructions)			28	18		2.00
3.00 HMO IPF Subprovider				34		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	172	13	254	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	92	9	196	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 RURAL HEALTH CLINIC	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		BCC DBA ILLINI COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1315 Component CCN: 14-3482		Period: From 10/01/2018 To 09/30/2019
			Worksheet S-8		Date/Time Prepared: 2/27/2020 10:33 pm
			RHC I		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street		640 WEST WASHINGTON		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		PITTSFIELD IL 62363		2.00
			1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)		5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		6.00		
7.00	Appalachian Regional Commission		7.00		
8.00	Look-Alikes		8.00		
9.00	OTHER (SPECIFY)		9.00		
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
			Sunday		Monday
			from	to	from
			1.00	2.00	3.00
			Tuesday		from
			1.00		2.00
11.00	Facility hours of operations (1)				
	CLINIC		07:00	17:30	07:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
			Y/N		V
			1.00		2.00
			XVIII		XIX
			3.00		4.00
			Total Visits		5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
			County		4.00
2.00	City, State, ZIP Code, County		PIKE		
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
			Thursday		from
			to		10.00
Facility hours of operations (1)					
11.00	CLINIC		17:30	07:00	17:30
			07:00		17:30
			11.00		

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1315 Component CCN: 14-3482		Period: From 10/01/2018 To 09/30/2019		Worksheet S-8 Date/Time Prepared: 2/27/2020 10:33 pm	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC		07:00	17:30	07:00	12:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/27/2020 10:33 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)		0.377514	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		933,455	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,219,513	5.00
6.00	Medicaid charges		14,351,225	6.00
7.00	Medicaid cost (line 1 times line 6)		5,417,788	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)		2,264,820	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)		2,264,820	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)	489,728	506,360	996,088
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	184,879	506,360	691,239
22.00	Payments received from patients for amounts previously written off as charity care	349	0	349
23.00	Cost of charity care (line 21 minus line 22)	184,530	506,360	690,890
				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)		2,620,825	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		872,776	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,342,733	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,278,092	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		952,455	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,643,345	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,908,165	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1315

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

Worksheet A

Date/Time Prepared:
2/27/2020 10:33 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		712,565	712,565	51,489	764,054	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		371,283	371,283	3,211	374,494	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,389,059	3,389,059	0	3,389,059	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,527,973	2,286,988	3,814,961	-23,348	3,791,613	5.00
6.00	00600	MAINTENANCE & REPAIRS	525,374	334,663	860,037	0	860,037	6.00
7.00	00700	OPERATION OF PLANT	0	400,750	400,750	42,928	443,678	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,412	82,412	0	82,412	8.00
9.00	00900	HOUSEKEEPING	313,593	143,224	456,817	0	456,817	9.00
10.00	01000	DIETARY	208,036	147,340	355,376	0	355,376	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	183,340	5,670	189,010	-71,103	117,907	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,198	38,296	72,494	0	72,494	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	215,216	215,216	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	28,710	28,710	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,077,827	314,984	1,392,811	-69,671	1,323,140	30.00
40.00	04000	SUBPROVIDER - IPF	926,400	89,033	1,015,433	-77,715	937,718	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	390,037	153,368	543,405	-8,327	535,078	50.00
53.00	05300	ANESTHESIOLOGY	28,710	11,004	39,714	-39,714	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,229	465,210	1,427,439	-1,429	1,426,010	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	41,163	29,620	70,783	-19,874	50,909	54.01
60.00	06000	LABORATORY	480,113	925,696	1,405,809	-39,634	1,366,175	60.00
65.00	06500	RESPIRATORY THERAPY	30,741	43,312	74,053	-19,490	54,563	65.00
65.01	03610	SLEEP LAB	335	41,662	41,997	0	41,997	65.01
66.00	06600	PHYSICAL THERAPY	74,144	53,728	127,872	0	127,872	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,773	150,894	235,667	114,913	350,580	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	432,606	3,544,586	3,977,192	-896	3,976,296	73.00
73.01	03480	ONCOLOGY	140,910	260,873	401,783	0	401,783	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	984,651	604,502	1,589,153	-763	1,588,390	88.00
91.00	09100	EMERGENCY	817,293	2,376,752	3,194,045	-12,301	3,181,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		95,363	95,363	0	95,363	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,264,446	17,072,837	26,337,283	72,202	26,409,485	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	76,218	34,578	110,796	0	110,796	192.00
192.01	19201	XPRESS CARE	418,604	46,264	464,868	0	464,868	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	130,462	71,165	201,627	-72,202	129,425	193.04
200.00		TOTAL (SUM OF LINES 118 through 199)	9,889,730	17,224,844	27,114,574	0	27,114,574	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1315

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

Worksheet A

Date/Time Prepared:
2/27/2020 10:33 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	205,153	969,207	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	87,014	461,508	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-576,149	2,812,910	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,105,425	5,897,038	5.00
6.00	00600	MAINTENANCE & REPAIRS	-11,868	848,169	6.00
7.00	00700	OPERATION OF PLANT	-5,465	438,213	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-87	82,325	8.00
9.00	00900	HOUSEKEEPING	0	456,817	9.00
10.00	01000	DIETARY	-55,901	299,475	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	117,907	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	246,463	318,957	16.00
17.00	01700	SOCIAL SERVICE	0	215,216	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	28,710	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	15,832	1,338,972	30.00
40.00	04000	SUBPROVIDER - IPF	0	937,718	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,603	533,475	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-12,298	1,413,712	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	50,909	54.01
60.00	06000	LABORATORY	-306,713	1,059,462	60.00
65.00	06500	RESPIRATORY THERAPY	0	54,563	65.00
65.01	03610	SLEEP LAB	-7,885	34,112	65.01
66.00	06600	PHYSICAL THERAPY	0	127,872	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,304	404,884	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,551	4,049,847	73.00
73.01	03480	ONCOLOGY	-253,000	148,783	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-84,925	1,503,465	88.00
91.00	09100	EMERGENCY	-1,714,227	1,467,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-95,363	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-337,742	26,071,743	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-56	110,740	192.00
192.01	19201	XPRESS CARE	-83	464,785	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	RENAL	0	0	193.01
193.02	19302	LEASED SPACE	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	193.03
193.04	19304	WELLNESS	0	129,425	193.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-337,881	26,776,693	200.00

RECLASSIFICATIONS

Provider CCN: 14-1315

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

Worksheet A-6

Date/Time Prepared:
2/27/2020 10:33 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	10,000	1.00	
	TOTALS		0	10,000		
	B - RECLASS UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	42,928	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	
	TOTALS		0	42,928		
	C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	114,913	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
	TOTALS		0	114,913		
	E - RECLASS INFECTION CONTROL SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	71,103	0	1.00	
	TOTALS		71,103	0		
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE					
1.00	OPERATING ROOM	50.00	0	11,004	1.00	
	TOTALS		0	11,004		
	H - RECLASS CRNA COSTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	28,710	0	1.00	
	TOTALS		28,710	0		
	J - RECLASS SOCIAL WORKER SALARIES					
1.00	SOCIAL SERVICE	17.00	215,216	0	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		215,216	0		
	K - RECLASS BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	44,700	1.00	
	TOTALS		0	44,700		
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	17,795	9,707	1.00	
	TOTALS		17,795	9,707		
500.00	Grand Total: Increases		332,824	233,252	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet A-6
Date/Time Prepared:
2/27/2020 10:33 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,000	0	1.00
	TOTALS		0	10,000		
B - RECLASS UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,386	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	117	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	117	0	3.00
4.00	LABORATORY	60.00	0	126	0	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	182	0	5.00
	TOTALS		0	42,928		
C - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	1,608	0	1.00
2.00	SUBPROVIDER - IPF	40.00	0	12	0	2.00
3.00	OPERATING ROOM	50.00	0	19,331	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,312	0	4.00
5.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	19,874	0	5.00
6.00	LABORATORY	60.00	0	39,508	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	19,490	0	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	714	0	8.00
9.00	EMERGENCY	91.00	0	12,301	0	9.00
10.00	RURAL HEALTH CLINIC	88.00	0	763	0	10.00
	TOTALS		0	114,913		
E - RECLASS INFECTION CONTROL SALARY						
1.00	NURSING ADMINISTRATION	13.00	71,103	0	0	1.00
	TOTALS		71,103	0		
F - RECLASS MISCELLANEOUS ANESTH EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	11,004	0	1.00
	TOTALS		0	11,004		
H - RECLASS CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	28,710	0	0	1.00
	TOTALS		28,710	0		
J - RECLASS SOCIAL WORKER SALARIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	69,567	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	67,946	0	0	2.00
3.00	SUBPROVIDER - IPF	40.00	77,703	0	0	3.00
	TOTALS		215,216	0		
K - RECLASS BUILDING RENT						
1.00	WELLNESS	193.04	0	44,700	10	1.00
	TOTALS		0	44,700		
L - RECLASS EMPLOYEE BENEFIT PERCENTAGE						
1.00	WELLNESS	193.04	17,795	9,707	0	1.00
	TOTALS		17,795	9,707		
500.00	Grand Total: Decreases		332,824	233,252		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/27/2020 10:33 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	279,691	0	0	0	0	1.00
2.00	Land Improvements	533,487	0	0	0	0	2.00
3.00	Buildings and Fixtures	12,805,883	361,819	0	361,819	53,592	3.00
4.00	Building Improvements	3,083,678	125,176	0	125,176	0	4.00
5.00	Fixed Equipment	73,264	0	0	0	0	5.00
6.00	Movable Equipment	7,588,489	385,653	0	385,653	252,665	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,364,492	872,648	0	872,648	306,257	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,364,492	872,648	0	872,648	306,257	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	279,691	0				1.00
2.00	Land Improvements	533,487	0				2.00
3.00	Buildings and Fixtures	13,114,110	0				3.00
4.00	Building Improvements	3,208,854	0				4.00
5.00	Fixed Equipment	73,264	0				5.00
6.00	Movable Equipment	7,721,477	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	24,930,883	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	24,930,883	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/27/2020 10:33 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	712,565	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	371,283	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,083,848	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	712,565				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	371,283				2.00
3.00	Total (sum of lines 1-2)	0	1,083,848				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/27/2020 10:33 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	16,322,963	0	16,322,963	0.678866	6,789	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,721,477	0	7,721,477	0.321134	3,211	2.00
3.00	Total (sum of lines 1-2)	24,044,440	0	24,044,440	1.000000	10,000	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	6,789	917,718	44,700	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,211	458,297	0	2.00
3.00	Total (sum of lines 1-2)	0	0	10,000	1,376,015	44,700	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	0	6,789	0	0	969,207	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,211	0	0	461,508	2.00
3.00	Total (sum of lines 1-2)	0	10,000	0	0	1,430,715	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1315

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

Worksheet A-8

Date/Time Prepared:
2/27/2020 10:33 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				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
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	-95,363	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-1,950,906			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	1,784,680			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	-25	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	-34	DIETARY	10.00	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
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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-78,575	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1315

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

Worksheet A-8

Date/Time Prepared:
2/27/2020 10:33 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	
33.01	MISCELLANEOUS SUPPLIES REVENUE	B	-10,430	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.01
33.02	PHYSICIAN RECRUITMENT	A	-68	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CABLE TELEVISION	A	-5,465	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANEOUS EXPENSE	A	-4,000	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PUBLIC RELATIONS EXPENSES	A	-74,726	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ASSET RELIFING	A	205,153	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07	ASSET RELIFING	A	83,605	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08	COFFEE SHOP RECEIPTS	B	-43,818	DIETARY	10.00	0	33.08
33.09	MEALS ON WHEELS	B	-13,091	DIETARY	10.00	0	33.09
33.10	LOBBYING EXPENSE	A	-10,332	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	ACCOUNTING FEES	B	-1,621	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	LABORATORY EXPENSE	A	-122,865	RURAL HEALTH CLINIC	88.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-337,881				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: 14-1315

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

Worksheet A-8-1

Date/Time Prepared:
2/27/2020 10:33 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	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,277,532	1,219,537	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	246,488	0	2.00
3.00	10.00	DIETARY	DIETICIAN	5,793	4,751	3.00
4.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	87,025	87,112	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	576,149	4.01
4.02	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	459,437	275,242	4.02
4.03	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	0	78,979	4.03
4.04	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	0	20,207	4.04
4.05	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN BENEFITS	0	46,791	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE	7,223	12,391	4.06
4.07	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	122,685	49,134	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	INFORMATICS	0	7,075	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	CARE MANAGEMENT	241,893	12,898	4.09
4.10	60.00	LABORATORY	LABORATORY TESTS	115,201	421,831	4.10
4.11	65.01	SLEEP LAB	SLEEP STUDIES	33,110	40,995	4.11
4.12	30.00	ADULTS & PEDIATRICS	BIO-MED	126	265	4.12
4.13	50.00	OPERATING ROOM	BIO-MED	139	292	4.13
4.14	91.00	EMERGENCY	BIO-MED	378	795	4.14
4.15	192.00	PHYSICIANS' PRIVATE OFFICES	BIO-MED	50	106	4.15
4.16	50.00	OPERATING ROOM	BIO-MED	1,315	2,765	4.16
4.17	192.01	XPRESS CARE	BIO-MED	76	159	4.17
4.18	88.00	RURAL HEALTH CLINIC	BIO-MED	252	530	4.18
4.19	60.00	LABORATORY	BIO-MED	76	159	4.19
4.20	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED	11,149	23,447	4.20
4.21	6.00	MAINTENANCE & REPAIRS	BIO-MED	10,759	22,627	4.21
4.22	30.00	ADULTS & PEDIATRICS	TELEMETRY SERVICES	26,981	11,010	4.22
4.23	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER	64,734	0	4.23
4.24	91.00	EMERGENCY	ER PHYSICIAN	397,292	413,906	4.24
4.25	2.00	CAP REL COSTS-MVBLE EQUIP	TELEMEDICINE ROBOT	11,929	8,520	4.25
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,121,643	3,336,963	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	BLESS CORP SVCS	0.00	6.00
7.00	G		0.00	BLESSING HOSP	0.00	7.00
8.00	G		0.00	DENMAN SERVICES	0.00	8.00
9.00	G		0.00	DENMAN SERVICES	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				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: 14-1315

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

Worksheet A-8-1

Date/Time Prepared:
2/27/2020 10:33 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	2,057,995	0		1.00
2.00	246,488	0		2.00
3.00	1,042	0		3.00
4.00	-87	0		4.00
4.01	-576,149	0		4.01
4.02	184,195	0		4.02
4.03	-78,979	0		4.03
4.04	-20,207	0		4.04
4.05	-46,791	0		4.05
4.06	-5,168	0		4.06
4.07	73,551	0		4.07
4.08	-7,075	0		4.08
4.09	228,995	0		4.09
4.10	-306,630	0		4.10
4.11	-7,885	0		4.11
4.12	-139	0		4.12
4.13	-153	0		4.13
4.14	-417	0		4.14
4.15	-56	0		4.15
4.16	-1,450	0		4.16
4.17	-83	0		4.17
4.18	-278	0		4.18
4.19	-83	0		4.19
4.20	-12,298	0		4.20
4.21	-11,868	0		4.21
4.22	15,971	0		4.22
4.23	64,734	0		4.23
4.24	-15,904	0		4.24
4.25	3,409	9		4.25
5.00	1,784,680			5.00

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

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

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

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

6.00	HOME OFFICE	6.00
7.00	HOSPITAL	7.00
8.00	LAUNDRY	8.00
9.00	BIO-MED	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: 14-1315

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2020 10:33 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	60.00	LABORATORY	13,654	0	13,654	0	0	1.00
2.00	73.01	ONCOLOGY	253,000	253,000	0	0	0	2.00
3.00	91.00	EMERGENCY	2,291,371	1,697,906	593,465	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	1,700	0	1,700	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,559,725	1,950,906	608,819	0	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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	73.01	ONCOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	73.01	ONCOLOGY	0	0	0	253,000		2.00
3.00	91.00	EMERGENCY	0	0	0	1,697,906		3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,950,906		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2018 To 09/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2020 10:33 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					220	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	444.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.90	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.95	41.95	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					37,252	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					37,252	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					37,252	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					83.90	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					65,442	22.00
23.00	Total salary equivalency (see instructions)					65,442	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					9,229	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,229	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					759	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,988	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					9,988	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2018 To 09/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2020 10:33 pm		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.90	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						65,442	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						9,988	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						75,430	63.00
64.00	Total cost of outside supplier services (from your records)						42,180	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						9,229	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						759	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						9,988	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						759	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						759	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	969,207	969,207			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	461,508		461,508		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,812,910	0	0	2,812,910	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,897,038	246,725	125,081	440,100	5.00
6.00	00600	MAINTENANCE & REPAIRS	848,169	169,090	85,724	149,430	6.00
7.00	00700	OPERATION OF PLANT	438,213	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	82,325	7,458	3,781	0	8.00
9.00	00900	HOUSEKEEPING	456,817	16,037	8,130	89,194	9.00
10.00	01000	DIETARY	299,475	15,276	7,745	59,171	10.00
11.00	01100	CAFETERIA	0	4,331	2,196	0	11.00
13.00	01300	NURSING ADMINISTRATION	117,907	1,455	738	31,923	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	318,957	10,493	5,320	9,727	16.00
17.00	01700	SOCIAL SERVICE	215,216	1,045	530	61,213	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	28,710	0	0	8,166	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,338,972	58,387	29,600	287,237	30.00
40.00	04000	SUBPROVIDER - IPF	937,718	46,606	23,628	241,392	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	533,475	44,758	22,691	110,937	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,413,712	28,470	14,434	273,684	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	50,909	3,679	1,865	11,708	54.01
60.00	06000	LABORATORY	1,059,462	16,681	8,457	136,557	60.00
65.00	06500	RESPIRATORY THERAPY	54,563	8,721	4,421	8,744	65.00
65.01	03610	SLEEP LAB	34,112	1,129	572	95	65.01
66.00	06600	PHYSICAL THERAPY	127,872	0	0	21,089	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	404,884	7,141	3,620	24,112	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,049,847	13,654	6,922	123,045	73.00
73.01	03480	ONCOLOGY	148,783	25,861	13,111	40,079	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,503,465	48,579	24,628	280,061	88.00
91.00	09100	EMERGENCY	1,467,517	42,141	21,364	232,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,071,743	817,717	414,558	2,640,124	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	110,740	26,004	13,183	21,678	192.00
192.01	19201	XPRESS CARE	464,785	0	8,211	119,062	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	0	14,440	0	0	193.01
193.02	19302	LEASED SPACE	0	56,514	0	0	193.02
193.03	19303	UNUSED SPACE	0	4,122	0	0	193.03
193.04	19304	WELLNESS	129,425	50,410	25,556	32,046	193.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,776,693	969,207	461,508	2,812,910	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,708,944					5.00
6.00	00600	MAINTENANCE & REPAIRS	418,700	1,671,113				6.00
7.00	00700	OPERATION OF PLANT	146,501	0	584,714			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,280	22,041	7,880	154,765		8.00
9.00	00900	HOUSEKEEPING	190,619	47,394	16,945	0	825,136	9.00
10.00	01000	DIETARY	127,597	45,145	16,141	0	23,257	10.00
11.00	01100	CAFETERIA	2,182	12,800	4,576	0	6,594	11.00
13.00	01300	NURSING ADMINISTRATION	50,824	4,300	1,537	0	2,215	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,171	31,011	11,087	0	15,976	16.00
17.00	01700	SOCIAL SERVICE	92,941	3,089	1,104	0	1,591	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	12,328	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	573,081	172,550	61,693	64,663	88,895	30.00
40.00	04000	SUBPROVIDER - IPF	417,674	137,734	49,244	90,102	70,956	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	237,986	132,273	47,291	0	68,143	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	578,465	84,138	30,082	0	43,345	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	22,787	10,872	3,887	0	5,601	54.01
60.00	06000	LABORATORY	408,251	49,296	17,625	0	25,396	60.00
65.00	06500	RESPIRATORY THERAPY	25,558	25,773	9,214	0	13,277	65.00
65.01	03610	SLEEP LAB	12,005	3,336	1,193	0	1,719	65.01
66.00	06600	PHYSICAL THERAPY	49,800	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,017	21,102	7,545	0	10,871	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,401,935	40,351	14,427	0	20,788	73.00
73.01	03480	ONCOLOGY	76,168	76,428	27,325	0	39,373	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	620,734	143,565	51,329	0	73,960	88.00
91.00	09100	EMERGENCY	589,558	124,538	44,526	0	64,158	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)	6,349,162	1,187,736	424,651	154,765	576,115	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	57,370	76,848	27,475	0	39,590	192.00
192.01	19201	XPRESS CARE	197,934	47,863	0	0	24,658	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	4,828	42,674	15,257	0	21,984	193.01
193.02	19302	LEASED SPACE	18,893	167,015	59,713	0	86,041	193.02
193.03	19303	UNUSED SPACE	1,378	0	4,355	0	0	193.03
193.04	19304	WELLNESS	79,379	148,977	53,263	0	76,748	193.04
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)	6,708,944	1,671,113	584,714	154,765	825,136	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
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To 09/30/2019Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	593,807					10.00
11.00	01100	CAFETERIA	0	32,679				11.00
13.00	01300	NURSING ADMINISTRATION	0	542	211,441			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	165	0	517,907		16.00
17.00	01700	SOCIAL SERVICE	0	1,040	0	0	377,769	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	139	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	248,101	4,879	50,124	23,808	157,837	30.00
40.00	04000	SUBPROVIDER - IPF	345,706	4,100	34,158	29,253	219,932	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,884	22,662	20,281	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	474	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,649	8,970	174,429	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	199	23	6,555	0	54.01
60.00	06000	LABORATORY	0	2,319	0	87,266	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	149	53	6,597	0	65.00
65.01	03610	SLEEP LAB	0	2	0	3,539	0	65.01
66.00	06600	PHYSICAL THERAPY	0	358	0	4,264	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	410	0	12,100	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,090	0	87,577	0	73.00
73.01	03480	ONCOLOGY	0	681	8,104	6,105	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	4,757	20,857	0	0	88.00
91.00	09100	EMERGENCY	0	3,948	58,946	55,659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	593,807	32,311	203,897	517,907	377,769	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	368	4,509	0	0	192.00
192.01	19201	XPRESS CARE	0	0	3,035	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
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)	593,807	32,679	211,441	517,907	377,769	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
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Part I
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	49,343				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,159,827	0	3,159,827	30.00
40.00	04000	SUBPROVIDER - IPF	0	2,648,203	0	2,648,203	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,242,381	0	1,242,381	50.00
53.00	05300	ANESTHESIOLOGY	49,343	49,817	0	49,817	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,654,378	0	2,654,378	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	118,085	0	118,085	54.01
60.00	06000	LABORATORY	0	1,811,310	0	1,811,310	60.00
65.00	06500	RESPIRATORY THERAPY	0	157,070	0	157,070	65.00
65.01	03610	SLEEP LAB	0	57,702	0	57,702	65.01
66.00	06600	PHYSICAL THERAPY	0	203,383	0	203,383	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	638,802	0	638,802	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,760,636	0	5,760,636	73.00
73.01	03480	ONCOLOGY	0	462,018	0	462,018	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,771,935	0	2,771,935	88.00
91.00	09100	EMERGENCY	0	2,704,815	0	2,704,815	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)	49,343	24,440,362	0	24,440,362	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	377,765	0	377,765	192.00
192.01	19201	XPRESS CARE	0	865,548	0	865,548	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	0	99,183	0	99,183	193.01
193.02	19302	LEASED SPACE	0	388,176	0	388,176	193.02
193.03	19303	UNUSED SPACE	0	9,855	0	9,855	193.03
193.04	19304	WELLNESS	0	595,804	0	595,804	193.04
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)	49,343	26,776,693	0	26,776,693	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	246,725	125,081	371,806	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	169,090	85,724	254,814	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,458	3,781	11,239	8.00
9.00	00900	HOUSEKEEPING	0	16,037	8,130	24,167	9.00
10.00	01000	DIETARY	0	15,276	7,745	23,021	10.00
11.00	01100	CAFETERIA	0	4,331	2,196	6,527	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,455	738	2,193	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,493	5,320	15,813	16.00
17.00	01700	SOCIAL SERVICE	0	1,045	530	1,575	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	58,387	29,600	87,987	30.00
40.00	04000	SUBPROVIDER - IPF	0	46,606	23,628	70,234	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	44,758	22,691	67,449	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,470	14,434	42,904	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	3,679	1,865	5,544	54.01
60.00	06000	LABORATORY	0	16,681	8,457	25,138	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,721	4,421	13,142	65.00
65.01	03610	SLEEP LAB	0	1,129	572	1,701	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,141	3,620	10,761	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,654	6,922	20,576	73.00
73.01	03480	ONCOLOGY	0	25,861	13,111	38,972	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	48,579	24,628	73,207	88.00
91.00	09100	EMERGENCY	0	42,141	21,364	63,505	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	817,717	414,558	1,232,275	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,004	13,183	39,187	192.00
192.01	19201	XPRESS CARE	22,980	0	8,211	31,191	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	0	14,440	0	14,440	193.01
193.02	19302	LEASED SPACE	0	56,514	0	56,514	193.02
193.03	19303	UNUSED SPACE	0	4,122	0	4,122	193.03
193.04	19304	WELLNESS	0	50,410	25,556	75,966	193.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,980	969,207	461,508	1,453,695	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	371,806					5.00
6.00	00600	MAINTENANCE & REPAIRS	23,205	278,019				6.00
7.00	00700	OPERATION OF PLANT	8,119	0	8,119			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,734	3,667	109	16,749		8.00
9.00	00900	HOUSEKEEPING	10,564	7,885	235	0	42,851	9.00
10.00	01000	DIETARY	7,072	7,511	224	0	1,208	10.00
11.00	01100	CAFETERIA	121	2,129	64	0	342	11.00
13.00	01300	NURSING ADMINISTRATION	2,817	715	21	0	115	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,383	5,159	154	0	830	16.00
17.00	01700	SOCIAL SERVICE	5,151	514	15	0	83	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	683	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,761	28,706	856	6,998	4,613	30.00
40.00	04000	SUBPROVIDER - IPF	23,148	22,914	684	9,751	3,685	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,189	22,006	657	0	3,539	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,059	13,998	418	0	2,251	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,263	1,809	54	0	291	54.01
60.00	06000	LABORATORY	22,626	8,201	245	0	1,319	60.00
65.00	06500	RESPIRATORY THERAPY	1,416	4,288	128	0	690	65.00
65.01	03610	SLEEP LAB	665	555	17	0	89	65.01
66.00	06600	PHYSICAL THERAPY	2,760	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,148	3,511	105	0	565	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,686	6,713	200	0	1,080	73.00
73.01	03480	ONCOLOGY	4,221	12,715	379	0	2,045	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	34,402	23,885	713	0	3,841	88.00
91.00	09100	EMERGENCY	32,674	20,719	618	0	3,332	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)	351,867	197,600	5,896	16,749	29,918	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	3,179	12,785	382	0	2,056	192.00
192.01	19201	XPRESS CARE	10,970	7,963	0	0	1,281	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	268	7,100	212	0	1,142	193.01
193.02	19302	LEASED SPACE	1,047	27,786	829	0	4,468	193.02
193.03	19303	UNUSED SPACE	76	0	60	0	0	193.03
193.04	19304	WELLNESS	4,399	24,785	740	0	3,986	193.04
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)	371,806	278,019	8,119	16,749	42,851	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2018
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	39,036					10.00
11.00	01100	CAFETERIA	0	9,183				11.00
13.00	01300	NURSING ADMINISTRATION	0	152	6,013			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46	0	28,385		16.00
17.00	01700	SOCIAL SERVICE	0	292	0	0	7,630	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	39	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,310	1,369	1,425	1,305	3,188	30.00
40.00	04000	SUBPROVIDER - IPF	22,726	1,153	971	1,603	4,442	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	530	644	1,111	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,307	255	9,563	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	56	1	359	0	54.01
60.00	06000	LABORATORY	0	652	0	4,782	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	42	1	361	0	65.00
65.01	03610	SLEEP LAB	0	0	0	194	0	65.01
66.00	06600	PHYSICAL THERAPY	0	101	0	234	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	115	0	663	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	587	0	4,799	0	73.00
73.01	03480	ONCOLOGY	0	191	230	335	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,337	593	0	0	88.00
91.00	09100	EMERGENCY	0	1,110	1,679	3,050	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,036	9,079	5,799	28,385	7,630	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	104	128	0	0	192.00
192.01	19201	XPRESS CARE	0	0	86	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
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)	39,036	9,183	6,013	28,385	7,630	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	722				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		184,518	0	184,518	30.00
40.00	04000	SUBPROVIDER - IPF		161,311	0	161,311	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		109,125	0	109,125	50.00
53.00	05300	ANESTHESIOLOGY		26	0	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		102,755	0	102,755	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		9,377	0	9,377	54.01
60.00	06000	LABORATORY		62,963	0	62,963	60.00
65.00	06500	RESPIRATORY THERAPY		20,068	0	20,068	65.00
65.01	03610	SLEEP LAB		3,221	0	3,221	65.01
66.00	06600	PHYSICAL THERAPY		3,095	0	3,095	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		23,868	0	23,868	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		111,641	0	111,641	73.00
73.01	03480	ONCOLOGY		59,088	0	59,088	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		137,978	0	137,978	88.00
91.00	09100	EMERGENCY		126,687	0	126,687	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	1,115,721	0	1,115,721	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		57,821	0	57,821	192.00
192.01	19201	XPRESS CARE		51,491	0	51,491	192.01
193.00	19300	NONPAID WORKERS		0	0	0	193.00
193.01	19301	RENAL		23,162	0	23,162	193.01
193.02	19302	LEASED SPACE		90,644	0	90,644	193.02
193.03	19303	UNUSED SPACE		4,258	0	4,258	193.03
193.04	19304	WELLNESS		109,876	0	109,876	193.04
200.00		Cross Foot Adjustments	722	722	0	722	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	722	1,453,695	0	1,453,695	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1315

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	115,916					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		108,874				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,889,730			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,508	29,508	1,547,304	-6,708,944	20,067,749	5.00
6.00	00600	MAINTENANCE & REPAIRS	20,223	20,223	525,373	0	1,252,413	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	438,213	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	0	0	93,564	8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	313,593	0	570,178	9.00
10.00	01000	DIETARY	1,827	1,827	208,036	0	381,667	10.00
11.00	01100	CAFETERIA	518	518	0	0	6,527	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	112,237	0	152,023	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	34,198	0	344,497	16.00
17.00	01700	SOCIAL SERVICE	125	125	215,216	0	278,004	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	28,710	0	36,876	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	1,009,881	0	1,714,196	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	848,697	0	1,249,344	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,353	5,353	390,037	0	711,861	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	962,229	0	1,730,300	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	41,163	0	68,161	54.01
60.00	06000	LABORATORY	1,995	1,995	480,114	0	1,221,157	60.00
65.00	06500	RESPIRATORY THERAPY	1,043	1,043	30,741	0	76,449	65.00
65.01	03610	SLEEP LAB	135	135	335	0	35,908	65.01
66.00	06600	PHYSICAL THERAPY	0	0	74,144	0	148,961	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	84,773	0	439,757	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,633	1,633	432,606	0	4,193,468	73.00
73.01	03480	ONCOLOGY	3,093	3,093	140,910	0	227,834	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	984,651	0	1,856,733	88.00
91.00	09100	EMERGENCY	5,040	5,040	817,293	0	1,763,482	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)	97,798	97,798	9,282,241	-6,708,944	18,991,573	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	3,110	3,110	76,218	0	171,605	192.00
192.01	19201	XPRESS CARE	0	1,937	418,604	0	592,058	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	1,727	0	0	0	14,440	193.01
193.02	19302	LEASED SPACE	6,759	0	0	0	56,514	193.02
193.03	19303	UNUSED SPACE	493	0	0	0	4,122	193.03
193.04	19304	WELLNESS	6,029	6,029	112,667	0	237,437	193.04
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)	969,207	461,508	2,812,910		6,708,944	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.361287	4.238918	0.284427		0.334315	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		371,806	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.018528	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: 14-1315

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

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:33 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	67,629					6.00
7.00	00700	OPERATION OF PLANT	0	66,185				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	2,616			8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	0	64,819		9.00
10.00	01000	DIETARY	1,827	1,827	0	1,827	2,616	10.00
11.00	01100	CAFETERIA	518	518	0	518	0	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	0	174	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	0	1,255	0	16.00
17.00	01700	SOCIAL SERVICE	125	125	0	125	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	1,093	6,983	1,093	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	1,523	5,574	1,523	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,353	5,353	0	5,353	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	0	3,405	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	0	440	0	54.01
60.00	06000	LABORATORY	1,995	1,995	0	1,995	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,043	1,043	0	1,043	0	65.00
65.01	03610	SLEEP LAB	135	135	0	135	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	0	854	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,633	1,633	0	1,633	0	73.00
73.01	03480	ONCOLOGY	3,093	3,093	0	3,093	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	0	5,810	0	88.00
91.00	09100	EMERGENCY	5,040	5,040	0	5,040	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,067	48,067	2,616	45,257	2,616	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	3,110	3,110	0	3,110	0	192.00
192.01	19201	XPRESS CARE	1,937	0	0	1,937	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	1,727	1,727	0	1,727	0	193.01
193.02	19302	LEASED SPACE	6,759	6,759	0	6,759	0	193.02
193.03	19303	UNUSED SPACE	0	493	0	0	0	193.03
193.04	19304	WELLNESS	6,029	6,029	0	6,029	0	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,671,113	584,714	154,765	825,136	593,807	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.710006	8.834540	59.160933	12.729848	226.990443	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	278,019	8,119	16,749	42,851	39,036	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.110944	0.122671	6.402523	0.661087	14.922018	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: 14-1315

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

Worksheet B-1

Date/Time Prepared:
2/27/2020 10:33 pm

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,764,153					11.00
13.00	01300	NURSING ADMINISTRATION	112,237	2,390,473				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,198	0	61,963,152			16.00
17.00	01700	SOCIAL SERVICE	215,216	0	0	2,616		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	28,710	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,009,881	566,678	2,848,571	1,093	0	30.00
40.00	04000	SUBPROVIDER - IPF	848,697	386,175	3,500,052	1,523	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	390,037	256,208	2,426,522	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	56,703	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,229	101,416	20,867,402	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	41,163	262	784,275	0	0	54.01
60.00	06000	LABORATORY	480,114	0	10,440,993	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	30,741	596	789,280	0	0	65.00
65.01	03610	SLEEP LAB	335	0	423,382	0	0	65.01
66.00	06600	PHYSICAL THERAPY	74,144	0	510,155	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,773	0	1,447,688	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	432,606	0	10,478,269	0	0	73.00
73.01	03480	ONCOLOGY	140,910	91,618	730,466	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	984,651	235,797	0	0	0	88.00
91.00	09100	EMERGENCY	817,293	666,438	6,659,394	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,687,935	2,305,188	61,963,152	2,616	100	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	76,218	50,973	0	0	0	192.00
192.01	19201	XPRESS CARE	0	34,312	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
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)	32,679	211,441	517,907	377,769	49,343	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004831	0.088452	0.008358	144.407110	493.430000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,183	6,013	28,385	7,630	722	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001358	0.002515	0.000458	2.916667	7.220000	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

Worksheet C
Part I
Date/Time Prepared:
2/27/2020 10:33 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 10:33 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	2,204,323		2,204,323			30.00
40.00	04000	SUBPROVIDER - IPF	3,500,052		3,500,052			40.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,382	2,408,140	2,426,522	0.512001	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	56,703	56,703	0.878560	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	979,913	19,887,489	20,867,402	0.127202	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	16,131	768,144	784,275	0.150566	0.000000	54.01
60.00	06000	LABORATORY	1,219,226	9,221,767	10,440,993	0.173481	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	402,521	386,759	789,280	0.199004	0.000000	65.00
65.01	03610	SLEEP LAB	0	423,382	423,382	0.136288	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	476,669	33,486	510,155	0.398669	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,326	1,296,362	1,447,688	0.441257	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	812,905	9,665,364	10,478,269	0.549770	0.000000	73.00
73.01	03480	ONCOLOGY	0	730,466	730,466	0.632498	0.000000	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,777,136	2,777,136			88.00
91.00	09100	EMERGENCY	14,032	6,645,362	6,659,394	0.406165	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	644,248	644,248	0.554850	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,795,480	54,944,808	64,740,288			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,795,480	54,944,808	64,740,288			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 10:33 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
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.512001			50.00
53.00	05300	ANESTHESIOLOGY	0.878560			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127202			54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.150566			54.01
60.00	06000	LABORATORY	0.173481			60.00
65.00	06500	RESPIRATORY THERAPY	0.199004			65.00
65.01	03610	SLEEP LAB	0.136288			65.01
66.00	06600	PHYSICAL THERAPY	0.398669			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.441257			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.549770			73.00
73.01	03480	ONCOLOGY	0.632498			73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.406165			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.554850			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: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/27/2020 10:33 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital 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	109,125	2,426,522	0.044972	14,898	670	50.00
53.00	05300 ANESTHESIOLOGY	26	56,703	0.000459	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	102,755	20,867,402	0.004924	582,020	2,866	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	9,377	784,275	0.011956	6,832	82	54.01
60.00	06000 LABORATORY	62,963	10,440,993	0.006030	456,962	2,755	60.00
65.00	06500 RESPIRATORY THERAPY	20,068	789,280	0.025426	203,057	5,163	65.00
65.01	03610 SLEEP LAB	3,221	423,382	0.007608	0	0	65.01
66.00	06600 PHYSICAL THERAPY	3,095	510,155	0.006067	124,264	754	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	23,868	1,447,688	0.016487	87,766	1,447	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	111,641	10,478,269	0.010655	266,464	2,839	73.00
73.01	03480 ONCOLOGY	59,088	730,466	0.080891	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	137,978	2,777,136	0.049684	0	0	88.00
91.00	09100 EMERGENCY	126,687	6,659,394	0.019024	2,103	40	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	20,874	644,248	0.032401	0	0	92.00
200.00	Total (lines 50 through 199)	790,766	59,035,913		1,744,366	16,616	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315

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

Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 10:33 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	50.00
53.00	05300	ANESTHESIOLOGY	49,343	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	49,343	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1315		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:33 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	2,426,522	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	49,343	0	56,703	0.870201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,867,402	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	784,275	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	10,440,993	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	789,280	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	423,382	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	510,155	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,447,688	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,478,269	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	730,466	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,777,136	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	6,659,394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	644,248	0.000000	92.00
200.00		Total (lines 50 through 199)	0	49,343	0	59,035,913		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 10:33 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	14,898	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	582,020	0	0	0	54.00	
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	6,832	0	0	0	54.01	
60.00	06000	LABORATORY	0.000000	456,962	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	203,057	0	0	0	65.00	
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01	
66.00	06600	PHYSICAL THERAPY	0.000000	124,264	0	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	87,766	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	266,464	0	0	0	73.00	
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
91.00	09100	EMERGENCY	0.000000	2,103	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)		1,744,366	0	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 10:33 pm

			Title XVIII		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.512001	0	1,255,489	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.878560	0	15,485	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127202	0	8,444,885	0	0	54.00	
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.150566	0	459,936	0	0	54.01	
60.00	06000	LABORATORY	0.173481	0	3,907,513	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.199004	0	216,004	0	0	65.00	
65.01	03610	SLEEP LAB	0.136288	0	150,803	0	0	65.01	
66.00	06600	PHYSICAL THERAPY	0.398669	0	18,962	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.441257	0	677,083	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.549770	0	5,500,695	16,784	0	73.00	
73.01	03480	ONCOLOGY	0.632498	0	391,863	0	0	73.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0			0	88.00	
91.00	09100	EMERGENCY	0.406165	0	2,267,429	1,753	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.554850	0	395,924	0	0	92.00	
200.00		Subtotal (see instructions)		0	23,702,071	18,537	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	23,702,071	18,537	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1315		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/27/2020 10:33 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	642,812	0		50.00
53.00	05300	ANESTHESIOLOGY	13,605	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,074,206	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	69,251	0		54.01
60.00	06000	LABORATORY	677,879	0		60.00
65.00	06500	RESPIRATORY THERAPY	42,986	0		65.00
65.01	03610	SLEEP LAB	20,553	0		65.01
66.00	06600	PHYSICAL THERAPY	7,560	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	298,768	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,024,117	9,227		73.00
73.01	03480	ONCOLOGY	247,853	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	920,950	712		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	219,678	0		92.00
200.00		Subtotal (see instructions)	7,260,218	9,939		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,260,218	9,939		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part II Date/Time Prepared: 2/27/2020 10:33 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		109,125	2,426,522	0.044972	284	13	50.00
53.00	05300	ANESTHESIOLOGY		26	56,703	0.000459	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		102,755	20,867,402	0.004924	95,297	469	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		9,377	784,275	0.011956	0	0	54.01
60.00	06000	LABORATORY		62,963	10,440,993	0.006030	228,713	1,379	60.00
65.00	06500	RESPIRATORY THERAPY		20,068	789,280	0.025426	1,515	39	65.00
65.01	03610	SLEEP LAB		3,221	423,382	0.007608	0	0	65.01
66.00	06600	PHYSICAL THERAPY		3,095	510,155	0.006067	19,435	118	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		23,868	1,447,688	0.016487	1,715	28	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		111,641	10,478,269	0.010655	140,365	1,496	73.00
73.01	03480	ONCOLOGY		59,088	730,466	0.080891	0	0	73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		137,978	2,777,136	0.049684	0	0	88.00
91.00	09100	EMERGENCY		126,687	6,659,394	0.019024	7,261	138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	644,248	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		769,892	59,035,913		494,585	3,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:33 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	49,343	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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)	49,343	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:33 pm	
			Title XVIII		Subprovider - IPF		PPS	
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	2,426,522	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	49,343	0	56,703	0.870201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,867,402	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	784,275	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	10,440,993	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	789,280	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	423,382	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	510,155	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,447,688	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,478,269	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	730,466	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,777,136	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	6,659,394	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	644,248	0.000000	92.00
200.00		Total (lines 50 through 199)	0	49,343	0	59,035,913		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 10:33 pm	
				Title XVIII		Subprovider - IPF		PPS	
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	284	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	95,297	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY		0.000000	228,713	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	1,515	0	0	0	65.00
65.01	03610	SLEEP LAB		0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0.000000	19,435	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	1,715	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	140,365	0	0	0	73.00
73.01	03480	ONCOLOGY		0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY		0.000000	7,261	0	200	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			494,585	0	200	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:

Worksheet D

Component CCN: 14-M315

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 10:33 pm

Title XVIII

Subprovider -
IPF

PPS

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	0.512001	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.878560	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127202	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.150566	0	0	0	54.01
60.00	06000	LABORATORY	0.173481	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.199004	0	0	0	65.00
65.01	03610	SLEEP LAB	0.136288	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.398669	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.441257	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.549770	0	0	816	73.00
73.01	03480	ONCOLOGY	0.632498	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000			0	88.00
91.00	09100	EMERGENCY	0.406165	200	0	81	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.554850	0	0	0	92.00
200.00		Subtotal (see instructions)		200	0	816	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		200	0	816	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:

Worksheet D

Component CCN: 14-M315

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 10:33 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs			
			Cost	Cost		
			Reimbursed	Reimbursed		
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	449		73.00
73.01	03480	ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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	449		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	449		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:

Worksheet D

Component CCN: 14-Z315

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 10:33 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	0.512001	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.878560	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127202	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.150566	0	0	0	0	54.01
60.00	06000	LABORATORY	0.173481	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.199004	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0.136288	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.398669	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.441257	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.549770	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.632498	0	0	0	0	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.406165	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.554850	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: 14-1315 Component CCN: 14-Z315		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/27/2020 10:33 pm
			Title XVIII		Swing Beds - SNF	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:33 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)		1,217	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		855	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)		725	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		73	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)		217	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		18	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)		54	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		502	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)		73	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)		217	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		154.38	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		159.96	20.00	
21.00	Total general inpatient routine service cost (see instructions)		3,159,827	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		2,779	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)		8,638	25.00	
26.00	Total swing-bed cost (see instructions)		808,830	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,350,997	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)		2,350,997	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,749.70	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,380,349	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)		1,380,349	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315

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

Worksheet D-1

Date/Time Prepared:
2/27/2020 10:33 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					437,989	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,818,338	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)					200,728	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					596,685	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					797,413	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)					130	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,749.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					357,461	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315

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

Worksheet D-1

Date/Time Prepared:
2/27/2020 10:33 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	184,518	3,159,827	0.058395	357,461	20,874
91.00	Nursing School cost	0	3,159,827	0.000000	357,461	0
92.00	Allied health cost	0	3,159,827	0.000000	357,461	0
93.00	All other Medical Education	0	3,159,827	0.000000	357,461	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:33 pm
		Title XVIII	Subprovider - IPF	PPS
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)		1,523	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,523	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,523	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		774	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,648,203	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,648,203	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)		2,648,203	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)		1,738.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,345,839	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)		1,345,839	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 10:33 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					140,867 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,486,706 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)					3,680 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,680 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,483,026 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315

Period:

Worksheet D-1

Component CCN: 14-M315

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:33 pm

Title XVIII

Subprovider -
IPF

PPS

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	0	2,648,203	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,648,203	0.000000	0	0	91.00
92.00	Allied health cost	0	2,648,203	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,648,203	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 10:33 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		1,296,417		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.512001	14,898	7,628	50.00
53.00	05300	ANESTHESIOLOGY	0.878560	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127202	582,020	74,034	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.150566	6,832	1,029	54.01
60.00	06000	LABORATORY	0.173481	456,962	79,274	60.00
65.00	06500	RESPIRATORY THERAPY	0.199004	203,057	40,409	65.00
65.01	03610	SLEEP LAB	0.136288	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.398669	124,264	49,540	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.441257	87,766	38,727	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.549770	266,464	146,494	73.00
73.01	03480	ONCOLOGY	0.632498	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.406165	2,103	854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.554850	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,744,366	437,989	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,744,366		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 10:33 pm	
		Title XVIII	Subprovider - IPF	PPS	
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
40.00	04000 SUBPROVIDER - IPF		1,769,290		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.512001	284	145	50.00
53.00	05300 ANESTHESIOLOGY	0.878560	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.127202	95,297	12,122	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.150566	0	0	54.01
60.00	06000 LABORATORY	0.173481	228,713	39,677	60.00
65.00	06500 RESPIRATORY THERAPY	0.199004	1,515	301	65.00
65.01	03610 SLEEP LAB	0.136288	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.398669	19,435	7,748	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.441257	1,715	757	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.549770	140,365	77,168	73.00
73.01	03480 ONCOLOGY	0.632498	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.406165	7,261	2,949	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.554850	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		494,585	140,867	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)		494,585		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1315 Component CCN: 14-Z315	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 10:33 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
40.00	04000	SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.512001	2,483	1,271	50.00
53.00	05300	ANESTHESIOLOGY	0.878560	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127202	45,776	5,823	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.150566	0	0	54.01
60.00	06000	LABORATORY	0.173481	84,956	14,738	60.00
65.00	06500	RESPIRATORY THERAPY	0.199004	55,186	10,982	65.00
65.01	03610	SLEEP LAB	0.136288	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.398669	217,091	86,547	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.441257	21,973	9,696	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.549770	99,112	54,489	73.00
73.01	03480	ONCOLOGY	0.632498	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.406165	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.554850	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		526,577	183,546	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)		526,577		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 10:33 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,270,157	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)		7,270,157	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		7,342,859	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		38,072	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,962,261	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,342,526	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,342,526	30.00
31.00	Primary payer payments		799	31.00
32.00	Subtotal (line 30 minus line 31)		3,341,727	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)		1,186,906	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		771,489	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,143,075	36.00
37.00	Subtotal (see instructions)		4,113,216	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,113,216	40.00
40.01	Sequestration adjustment (see instructions)		82,264	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,733,476	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		297,476	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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 10:33 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		449	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		81	2.00
3.00	OPPS payments		170	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)		449	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		816	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)		816	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		816	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		367	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)		449	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)		170	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	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)		619	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)		619	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		619	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		619	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	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)		619	40.00
40.01	Sequestration adjustment (see instructions)		12	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		578	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		29	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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/27/2020 10:33 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		1,381,221		4,018,288	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	09/12/2019	197,107		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0	09/12/2019	284,812	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)		197,107		-284,812	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)		1,578,328		3,733,476	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		109,180		297,476	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,687,508		4,030,952	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: 14-1315
 Component CCN: 14-M315

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/27/2020 10:33 pm

		Title XVIII		Subprovider - IPF		PPS	
		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		770,087		578	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		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		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)		770,087		578	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		53,135		29	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		823,222		607	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-1315
 Component CCN: 14-Z315

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/27/2020 10:33 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		835,664		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	09/12/2019	106,281		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		106,281		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)		941,945		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		25,191		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		967,136		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: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part II
Date/Time Prepared:
2/27/2020 10:33 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: 14-1315 Component CCN: 14-Z315	Period: From 10/01/2018 To 09/30/2019	Worksheet E-2 Date/Time Prepared: 2/27/2020 10:33 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)		805,387	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)		185,381	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		290	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)		990,768	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		990,768	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)		990,768	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		3,895	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)		986,873	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)		986,873	0	19.00
19.01	Sequestration adjustment (see instructions)		19,737	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		941,945	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)		25,191	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: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/27/2020 10:33 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,818,338	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)		1,818,338	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,836,521	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)		1,836,521	19.00
20.00	Deductibles (exclude professional component)		161,644	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,674,877	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,674,877	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		72,416	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		47,070	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		71,100	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,721,947	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)		1,721,947	30.00
30.01	Sequestration adjustment (see instructions)		34,439	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,578,328	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)		109,180	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part II Date/Time Prepared: 2/27/2020 10:33 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		758,522	1.00
2.00	Net IPF PPS Outlier Payments		137,765	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		4.172603	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		896,287	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		896,287	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		896,287	18.00
19.00	Deductibles		89,712	19.00
20.00	Subtotal (line 18 minus line 19)		806,575	20.00
21.00	Coinsurance		20,770	21.00
22.00	Subtotal (line 20 minus line 21)		785,805	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		83,411	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		54,217	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		82,095	25.00
26.00	Subtotal (sum of lines 22 and 24)		840,022	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		840,022	31.00
31.01	Sequestration adjustment (see instructions)		16,800	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		770,087	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		53,135	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		137,765	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-1315

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

Worksheet G

Date/Time Prepared:
2/27/2020 10:33 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	10,683,153	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	11,744,043	0	0	0	4.00
5.00	Other receivable	-184,330	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,605,000	0	0	0	6.00
7.00	Inventory	647,845	0	0	0	7.00
8.00	Prepaid expenses	184,933	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,470,644	0	0	0	11.00
FIXED ASSETS						
12.00	Land	279,691	0	0	0	12.00
13.00	Land improvements	533,487	0	0	0	13.00
14.00	Accumulated depreciation	-409,996	0	0	0	14.00
15.00	Buildings	17,854,277	0	0	0	15.00
16.00	Accumulated depreciation	-6,821,964	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	7,721,477	0	0	0	23.00
24.00	Accumulated depreciation	-5,565,121	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,591,851	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	140,420	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	140,420	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,202,915	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,861,203	0	0	0	37.00
38.00	Salaries, wages, and fees payable	960,385	0	0	0	38.00
39.00	Payroll taxes payable	133,687	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	271,571	0	0	0	43.00
44.00	Other current liabilities	1,808,062	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,034,908	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	2,610,979	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	106,042	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,717,021	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,751,929	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	21,450,986				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)	21,450,986	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,202,915	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1315

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

Worksheet G-1

Date/Time Prepared:
2/27/2020 10:33 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		18,806,967		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,644,018				2.00
3.00	Total (sum of line 1 and line 2)		21,450,985		0		3.00
4.00	ROUNDING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		21,450,986		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,450,986		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	ROUNDING		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1315

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2020 10:33 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,867,545		1,867,545	1.00
2.00	SUBPROVIDER - IPF	3,554,281		3,554,281	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	279,855		279,855	5.00
6.00	Swing bed - NF	69,481		69,481	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)	5,771,162		5,771,162	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,771,162		5,771,162	17.00
18.00	Ancillary services	4,394,998	57,031,823	61,426,821	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,777,136	2,777,136	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	PHYSICIANS PRIVATE OFFICE	0	338,401	338,401	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,166,160	60,147,360	70,313,520	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,114,574		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)		27,114,574		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1315

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

Worksheet G-3

Date/Time Prepared:
2/27/2020 10:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	70,313,520	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,382,488	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,931,032	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,114,574	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,816,458	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	34,103	6.00
7.00	Income from investments	12,136	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	56,909	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	121,254	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	603,158	24.00
25.00	Total other income (sum of lines 6-24)	827,560	25.00
26.00	Total (line 5 plus line 25)	2,644,018	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,644,018	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315

Period:

Worksheet M-1

Component CCN: 14-3482

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:33 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	97,082	0	97,082	0	97,082	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	384,189	0	384,189	0	384,189	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	281,312	0	281,312	0	281,312	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	762,583	0	762,583	0	762,583	10.00
11.00	Physician Services Under Agreement	0	330,549	330,549	0	330,549	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	171,857	171,857	0	171,857	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	502,406	502,406	0	502,406	14.00
15.00	Medical Supplies	0	763	763	-763	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	70,043	70,043	0	70,043	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	70,806	70,806	-763	70,043	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	762,583	573,212	1,335,795	-763	1,335,032	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	830	830	0	830	29.00
30.00	Administrative Costs	222,068	30,460	252,528	0	252,528	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	222,068	31,290	253,358	0	253,358	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	984,651	604,502	1,589,153	-763	1,588,390	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315

Period:

Worksheet M-1

Component CCN: 14-3482

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:33 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	97,082	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	384,189	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	281,312	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	762,583	10.00
11.00	Physician Services Under Agreement	85,009	415,558	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	-169,656	2,201	13.00
14.00	Subtotal (sum of lines 11 through 13)	-84,647	417,759	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	70,043	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	70,043	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-84,647	1,250,385	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-278	552	29.00
30.00	Administrative Costs	0	252,528	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-278	253,080	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-84,925	1,503,465	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1315

Period:

Worksheet M-2

Component CCN: 14-3482

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 10:33 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	1.34	2,726	4,200	5,628		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.60	6,050	2,100	5,460		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.94	8,776		11,088	11,088	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	1.07	963			963	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.01	9,739			12,051	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)					1,250,385	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)					1,250,385	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)					253,080	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,268,470	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,521,550	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,521,550	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,521,550	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,771,935	20.00

Health Financial Systems		BCC DBA ILLINI COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1315	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN: 14-3482		Date/Time Prepared: 2/27/2020 10:33 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)			2,771,935	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			77,267	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,694,668	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,051	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)			12,051	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			223.61	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)		223.61	223.61	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		556	1,935	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		124,327	432,685	11.00
12.00	Program covered visits for mental health services (from contractor records)		26	82	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		5,814	18,336	13.00
14.00	Limit adjustment for mental health services (see instructions)		5,814	18,336	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	581,162	16.00
16.01	Total program charges (see instructions)(from contractor's records)			626,516	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			22,685	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			21,043	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.)			411,978	16.04
16.05	Total program cost (see instructions)		0	433,021	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			45,147	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			111,737	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			433,021	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			30,306	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			463,327	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)			463,327	26.00
26.01	Sequestration adjustment (see instructions)			9,267	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			517,580	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)			-63,520	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: 14-1315 Component CCN: 14-3482	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 10:33 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)		762,583	762,583	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000843	0.003017	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		643	2,301	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		24,111	7,799	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		24,754	10,100	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,250,385	1,250,385	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,521,550	1,521,550	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.019797	0.008078	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		30,122	12,291	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		54,876	22,391	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		152	544	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		361.03	41.16	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		60	210	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		21,662	8,644	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)			77,267	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)			30,306	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 10:33 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		472,541	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		09/12/2019	45,039	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		45,039	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		517,580	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		63,520	6.02
7.00	Total Medicare program liability (see instructions)		454,060	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00