

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: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/28/2020 1:22 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/28/2020	Time: 1:22 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 OSF HOLY FAMILY MED CTR (14-1318) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	22,823	88,677	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	116,127	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		234,058		0	10.00
200.00	Total	0	138,950	322,735	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: 14-1318		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 1:22 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1000 WEST HARLEM AVENUE			PO Box:				1.00	
2.00	City: MONMOUTH			State: IL		Zip Code: 61462		County: WARREN	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			OSF HOLY FAMILY MED CTR	141318	99914	1	05/01/2002	N
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			OSF HOLY FAMILY SWING BEDS	142318	99914		05/01/2002	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			OSF HOLY FAMILY CLINICS	143461	99914		02/05/2003	N
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018	09/30/2019	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1318

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From 10/01/2018
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural S	Date of Geogr		
					1.00	2.00		
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2						26.00	
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27.00	
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:		
					1.00	2.00		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0						37.00	
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
					Y/N	Y/N		
					1.00	2.00		
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N					N	39.00	
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N					N	40.00	
					V	XVIII	XIX	
					1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital								
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals								
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N							56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N							58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N							59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N						60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1318

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From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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

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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	N	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.	N		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.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 1:22 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	320,323	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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		149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1318		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 1:22 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: OSF HEALTHCARE SYSTEM		Contractor's Name: NGS		Contractor's Number: 06101				141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE		PO Box:						142.00
143.00	City: PEORIA		State: IL		Zip Code: 61603				143.00
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
								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: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/28/2020 1:22 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)	N		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	01/29/2020 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 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/13/2019	Y 12/13/2019 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N 19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/28/2020 1:22 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		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.	REBECCA C	ROBINSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(309)624-7644	REBECCA.C.ROBINSON@OSFHEALTHCARE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/28/2020 1:22 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.	GOVERNMENT REPORTING SENIOR ANALYST	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: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 1:22 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	23	8,395	14,256.00	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)		23	8,395	14,256.00	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)		23	8,395	14,256.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 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)		23				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: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 1:22 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)	347	31	594			1.00
2.00	HMO and other (see instructions)	92	92				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	505	22	567			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	115			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	852	53	1,276			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)	852	53	1,276	0.00	152.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	6,148	0	29,098	0.00	9.49	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	161.49	27.00
28.00	Observation Bed Days		26	152			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 1:22 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	120	9	199	1.00
2.00 HMO and other (see instructions)			28	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	120	9	199	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 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		OSF HOLY FAMILY MED CTR		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1318 Component CCN: 14-3461		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/28/2020 1:22 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1000 W. HARLEM		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MONMOUTH		ILLINOIS 61462	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:00		20:00	07:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	WARREN		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	20:00	07:00	20:00	07:00
		20:00	07:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2018 To 09/30/2019	Worksheet S-8 Date/Time Prepared: 2/28/2020 1:22 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	20:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/28/2020 1:22 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)			0.364304	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			5,682,708	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			14,620,308	6.00
7.00	Medicaid cost (line 1 times line 6)			5,326,237	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)			0	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)			0	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)	1,290,798	436,562	1,727,360	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	470,243	436,562	906,805	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	470,243	436,562	906,805	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,161,882	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			304,068	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			467,797	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,694,085	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			780,891	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,687,696	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,687,696	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1318		Period: From 10/01/2018 To 09/30/2019		Worksheet A Date/Time Prepared: 2/28/2020 1:22 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		432,524	432,524	363,795	796,319	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		312,901	312,901	402,013	714,914	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,209,037	2,209,037	1,569,657	3,778,694	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,223,740	6,438,967	7,662,707	-975,836	6,686,871	5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00	
7.00	00700	OPERATION OF PLANT	362,388	916,853	1,279,241	-188,953	1,090,288	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	95,273	95,273	8.00	
9.00	00900	HOUSEKEEPING	335,317	115,115	450,432	-97,736	352,696	9.00	
10.00	01000	DIETARY	272,932	117,263	390,195	-11,495	378,700	10.00	
11.00	01100	CAFETERIA	0	0	0	0	0	11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00	
15.00	01500	PHARMACY	0	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	153,700	12,161	165,861	0	165,861	16.00	
17.00	01700	SOCIAL SERVICE	105,477	2,706	108,183	200,285	308,468	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	978,744	95,628	1,074,372	-75,250	999,122	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	458,226	251,772	709,998	-209,995	500,003	50.00	
53.00	05300	ANESTHESIOLOGY	197,888	55,198	253,086	-3,659	249,427	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	599,412	203,355	802,767	139,393	942,160	54.00	
56.00	05600	RADIOISOTOPE	31,691	34,571	66,262	-3,953	62,309	56.00	
57.00	05700	CT SCAN	0	51,146	51,146	-49,690	1,456	57.00	
58.00	05800	MRI	0	242,943	242,943	-768	242,175	58.00	
60.00	06000	LABORATORY	479,857	488,328	968,185	-10,157	958,028	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	132,140	10,820	142,960	-7,855	135,105	65.00	
66.00	06600	PHYSICAL THERAPY	339,946	2,059	342,005	16,857	358,862	66.00	
67.00	06700	OCCUPATIONAL THERAPY	93,068	1,850	94,918	5,087	100,005	67.00	
68.00	06800	SPEECH PATHOLOGY	14,990	672	15,662	996	16,658	68.00	
69.00	06900	ELECTROCARDIOLOGY	198,577	28,730	227,307	-17,435	209,872	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-32,403	-32,403	288,697	256,294	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,435	46,435	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	220,963	1,647,022	1,867,985	236,029	2,104,014	73.00	
76.00	03950	DIABETIC SERVICES	58,663	6,806	65,469	-4,258	61,211	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	3,286,594	2,419,640	5,706,234	-1,221,990	4,484,244	88.00	
91.00	09100	EMERGENCY	989,817	2,699,611	3,689,428	-485,487	3,203,941	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	
SPECIAL PURPOSE COST CENTERS									
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,534,130	18,765,275	29,299,405	0	29,299,405	118.00	
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
200.00		TOTAL (SUM OF LINES 118 through 199)	10,534,130	18,765,275	29,299,405	0	29,299,405	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1318

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

Worksheet A

Date/Time Prepared:
2/28/2020 1:22 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	468,577	1,264,896	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	366,848	1,081,762	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-294,647	3,484,047	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-865,722	5,821,149	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	1,090,288	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,273	8.00
9.00	00900	HOUSEKEEPING	0	352,696	9.00
10.00	01000	DIETARY	-58,680	320,020	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,857	161,004	16.00
17.00	01700	SOCIAL SERVICE	-27,975	280,493	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	999,122	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	500,003	50.00
53.00	05300	ANESTHESIOLOGY	-197,888	51,539	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-16,610	925,550	54.00
56.00	05600	RADIOISOTOPE	0	62,309	56.00
57.00	05700	CT SCAN	0	1,456	57.00
58.00	05800	MRI	0	242,175	58.00
60.00	06000	LABORATORY	0	958,028	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	135,105	65.00
66.00	06600	PHYSICAL THERAPY	0	358,862	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	100,005	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,658	68.00
69.00	06900	ELECTROCARDIOLOGY	0	209,872	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	256,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	46,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-400,196	1,703,818	73.00
76.00	03950	DIABETIC SERVICES	-1,375	59,836	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	4,484,244	88.00
91.00	09100	EMERGENCY	-1,933,543	1,270,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,966,068	26,333,337	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,966,068	26,333,337	200.00

RECLASSIFICATIONS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet A-6
Date/Time Prepared:
2/28/2020 1:22 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MAINTENANCE COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	236,051		1.00
2.00	LABORATORY	60.00	0	39,642		2.00
	0		0	275,693		
	B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	294,654		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	216,488		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	0		0	511,142		
	F - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	19,160		1.00
	0		0	19,160		
	G - EMPLOYEE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,186,683		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
	0		0	1,186,683		
	I - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	350,127		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	396,521		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	15,002		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	761,650		
	J - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	27,109	68,164		1.00
	0		27,109	68,164		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	46,435		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
	0		0	46,435		
	L - CLINIC A&G					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,837		1.00
	0		0	17,837		
	M - MINISTRY ALLOCATION RECLASS					
1.00	OPERATION OF PLANT	7.00	0	63,808		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	37,958		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	382,974		3.00
4.00	PHYSICAL THERAPY	66.00	0	21,750		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	6,036		5.00
6.00	SPEECH PATHOLOGY	68.00	0	996		6.00
7.00	SOCIAL SERVICE	17.00	0	200,285		7.00
	0		0	713,807		
500.00	Grand Total: Increases		27,109	3,600,571		500.00

RECLASSIFICATIONS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet A-6
Date/Time Prepared:
2/28/2020 1:22 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MAINTENANCE COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	275,693	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	275,693			
	B - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	29,543	0		1.00
2.00	OPERATING ROOM	50.00	0	87,458	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	2,195	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,537	0		4.00
5.00	RADIOISOTOPE	56.00	0	630	0		5.00
6.00	CT SCAN	57.00	0	31,168	0		6.00
7.00	MRI	58.00	0	768	0		7.00
8.00	LABORATORY	60.00	0	27,466	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	5,860	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	3,556	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	949	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	4,969	0		12.00
13.00	DIABETIC SERVICES	76.00	0	4,258	0		13.00
14.00	RURAL HEALTH CLINIC	88.00	0	228,918	0		14.00
15.00	EMERGENCY	91.00	0	68,867	0		15.00
	0		0	511,142			
	F - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,160	0		1.00
	0		0	19,160			
	G - EMPLOYEE BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15	0		1.00
2.00	OPERATION OF PLANT	7.00	0	4,533	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	8,015	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	787,837	0		4.00
5.00	EMERGENCY	91.00	0	386,283	0		5.00
	0		0	1,186,683			
	I - DEPRECIATION RECLASS						
1.00	OPERATION OF PLANT	7.00	0	248,228	9		1.00
2.00	HOUSEKEEPING	9.00	0	2,463	9		2.00
3.00	DIETARY	10.00	0	11,495	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	36,826	0		4.00
5.00	OPERATING ROOM	50.00	0	76,990	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	1,464	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	82,121	0		7.00
8.00	RADIOISOTOPE	56.00	0	3,323	0		8.00
9.00	CT SCAN	57.00	0	18,522	0		9.00
10.00	LABORATORY	60.00	0	22,333	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	1,995	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	1,337	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	12,466	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,957	0		14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	18,417	0		15.00
16.00	RURAL HEALTH CLINIC	88.00	0	187,390	0		16.00
17.00	EMERGENCY	91.00	0	30,323	0		17.00
	0		0	761,650			
	J - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	27,109	68,164	0		1.00
	0		27,109	68,164			
	K - IMPLANTABLE DEVICES						
1.00	ADULTS & PEDIATRICS	30.00	0	866	0		1.00
2.00	EMERGENCY	91.00	0	14	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	8	0		3.00
4.00	OPERATING ROOM	50.00	0	45,547	0		4.00
	0		0	46,435			
	L - CLINIC A&G						
1.00	RURAL HEALTH CLINIC	88.00	0	17,837	0		1.00
	0		0	17,837			
	M - MINISTRY ALLOCATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	713,807	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		0	713,807			
500.00	Grand Total: Decreases		27,109	3,600,571			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/28/2020 1:22 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	325,000	0	0	0	0	1.00
2.00	Land Improvements	363,373	6,360	0	6,360	0	2.00
3.00	Buildings and Fixtures	16,112,722	3,108,136	0	3,108,136	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,880,555	122,112	0	122,112	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,681,650	3,236,608	0	3,236,608	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,681,650	3,236,608	0	3,236,608	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	325,000	0				1.00
2.00	Land Improvements	369,733	0				2.00
3.00	Buildings and Fixtures	19,220,858	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	8,002,667	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	27,918,258	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	27,918,258	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/28/2020 1:22 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	432,524	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	312,901	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	745,425	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	432,524				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	312,901				2.00
3.00	Total (sum of lines 1-2)	0	745,425				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/28/2020 1:22 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	19,915,591	0	19,915,591	0.713354	13,668	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,002,667	0	8,002,667	0.286646	5,492	2.00
3.00	Total (sum of lines 1-2)	27,918,258	0	27,918,258	1.000000	19,160	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	13,668	1,133,683	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,492	991,235	0	2.00
3.00	Total (sum of lines 1-2)	0	0	19,160	2,124,918	0	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	117,545	13,668	0	0	1,264,896	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	85,035	5,492	0	0	1,081,762	2.00
3.00	Total (sum of lines 1-2)	202,580	19,160	0	0	2,346,658	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1318

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

Worksheet A-8

Date/Time Prepared:
2/28/2020 1:22 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	-286	ADMINISTRATIVE & GENERAL	5.00	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)	A	-7,696	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,131,431			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	501,478			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-58,680	DIETARY	10.00	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	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients	B	-400,196	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,857	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-108,936	ADMINISTRATIVE & GENERAL	5.00	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	A	265,166	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	115,027	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RHC OTHER INCOME	B	0	RURAL HEALTH CLINIC	88.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1318

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

Worksheet A-8

Date/Time Prepared:
2/28/2020 1:22 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	
34.02	MARKETING & DEVELOPMENT OTHER	A		0ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.05	ADVERTISING EXPENSE	A		0ADMINISTRATIVE & GENERAL	5.00	0	34.05
35.00	LOBBYING	A	-11,563	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	ER BENEFITS	A	-5,707	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
37.01	SHARED ED BENEFITS	A	-288,940	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.01
38.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.01
38.02	PROVIDER TAX IDPA	A	-828,072	ADMINISTRATIVE & GENERAL	5.00	0	38.02
39.00	OTHER REVENUE-DIABETES	B	-1,375	DIABETIC SERVICES	76.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,966,068				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: 14-1318

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

Worksheet A-8-1

Date/Time Prepared:
2/28/2020 1:22 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CORP OFFICE CHARGES	85,866	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CORP OFFICE CHARGES	414,275	247,489	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CORP OFFICE CHARGES	1,383,320	3,271,120	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CORP OFFICE CHARGES	382,974	382,974	3.01
3.02	7.00	OPERATION OF PLANT	CORP OFFICE CHARGES	63,808	63,808	3.02
3.03	54.00	RADIOLOGY-DIAGNOSTIC	CORP OFFICE CHARGES	236,051	236,051	3.03
3.04	60.00	LABORATORY	CORP OFFICE CHARGES	39,642	39,642	3.04
3.05	66.00	PHYSICAL THERAPY	CORP OFFICE CHARGES	21,750	21,750	3.05
3.06	67.00	OCCUPATIONAL THERAPY	CORP OFFICE CHARGES	6,036	6,036	3.06
3.07	68.00	SPEECH PATHOLOGY	CORP OFFICE CHARGES	996	996	3.07
3.08	73.00	DRUGS CHARGED TO PATIENTS	CORP OFFICE CHARGES	92,845	92,845	3.08
3.09	6.00	MAINTENANCE & REPAIRS	CORP OFFICE CHARGES	198,739	198,739	3.09
4.00	1.00	CAP REL COSTS-BLDG & FIXT	CORP OFFICE CHARGES - INTERE	117,545	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	CORP OFFICE CHARGES - INTERE	85,035	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	CORP OFFICE CHARGES	165,161	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	CORP OFFICE CHARGES	1,813,470	0	4.03
4.04	17.00	SOCIAL SERVICE	CORP OFFICE CHARGES	172,310	200,285	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	SFI PURCHASE SERVICES	80,226	96,836	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,360,049	4,858,571	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	OSF HEALTHCARE SYSTEM	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-1318

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

Worksheet A-8-1

Date/Time Prepared:
2/28/2020 1:22 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	85,866	9		1.00
2.00	166,786	9		2.00
3.00	-1,887,800	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
4.00	117,545	11		4.00
4.01	85,035	11		4.01
4.02	165,161	0		4.02
4.03	1,813,470	0		4.03
4.04	-27,975	0		4.04
4.05	-16,610	0		4.05
5.00	501,478			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1318

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

Worksheet A-8-2

Date/Time Prepared:
2/28/2020 1:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,528,099	1,897,803	630,296	0	0	1.00
2.00	60.00	LABORATORY	14,400	0	14,400	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	247,892	197,888	50,004	0	0	3.00
4.00	91.00	EMERGENCY	35,740	35,740	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			2,826,131	2,131,431	694,700	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	1,897,803		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	197,888		3.00
4.00	91.00	EMERGENCY	0	0	0	35,740		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	2,131,431		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	1,264,896	1,264,896			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,081,762		1,081,762		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,484,047	0	0	3,484,047	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,821,149	220,458	188,541	413,507	6,643,655
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	1,090,288	143,269	122,526	122,452	1,478,535
8.00	00800	LAUNDRY & LINEN SERVICE	95,273	0	0	9,160	104,433
9.00	00900	HOUSEKEEPING	352,696	15,119	12,930	104,145	484,890
10.00	01000	DIETARY	320,020	85,624	73,227	92,225	571,096
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	161,004	22,516	19,256	51,936	254,712
17.00	01700	SOCIAL SERVICE	280,493	0	0	35,641	316,134
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	999,122	137,585	117,665	330,722	1,585,094
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	500,003	69,597	59,521	154,836	783,957
53.00	05300	ANESTHESIOLOGY	51,539	2,998	2,564	0	57,101
54.00	05400	RADIOLOGY-DIAGNOSTIC	925,550	65,120	55,692	202,544	1,248,906
56.00	05600	RADIOISOTOPE	62,309	0	0	10,709	73,018
57.00	05700	CT SCAN	1,456	0	0	0	1,456
58.00	05800	MRI	242,175	0	0	0	242,175
60.00	06000	LABORATORY	958,028	24,657	21,087	162,146	1,165,918
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	135,105	0	0	44,651	179,756
66.00	06600	PHYSICAL THERAPY	358,862	57,632	49,288	114,869	580,651
67.00	06700	OCCUPATIONAL THERAPY	100,005	3,647	3,119	31,448	138,219
68.00	06800	SPEECH PATHOLOGY	16,658	454	388	5,065	22,565
69.00	06900	ELECTROCARDIOLOGY	209,872	21,555	18,434	67,100	316,961
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	256,294	45,784	39,155	0	341,233
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,435	0	0	0	46,435
73.00	07300	DRUGS CHARGED TO PATIENTS	1,703,818	14,418	12,330	74,664	1,805,230
76.00	03950	DIABETIC SERVICES	59,836	15,949	13,640	19,822	109,247
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,484,244	203,289	173,857	1,110,552	5,971,942
91.00	09100	EMERGENCY	1,270,398	79,434	67,933	325,853	1,743,618
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,333,337	1,229,105	1,051,153	3,484,047	26,266,937
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	35,791	30,609	0	66,400
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	26,333,337	1,264,896	1,081,762	3,484,047	26,333,337

COST ALLOCATION - GENERAL SERVICE COSTS

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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	6,643,655					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	498,884	0	1,977,419			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,238	0	0	139,671		8.00
9.00	00900	HOUSEKEEPING	163,611	0	33,174	0	681,675	9.00
10.00	01000	DIETARY	192,698	0	187,884	0	65,874	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	85,944	0	49,406	0	17,322	16.00
17.00	01700	SOCIAL SERVICE	106,669	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	534,839	0	301,901	45,783	105,850	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	264,521	0	152,716	12,920	53,544	50.00
53.00	05300	ANESTHESIOLOGY	19,267	0	6,578	0	2,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421,403	0	142,892	25,044	50,100	54.00
56.00	05600	RADIOISOTOPE	24,638	0	0	0	0	56.00
57.00	05700	CT SCAN	491	0	0	0	0	57.00
58.00	05800	MRI	81,714	0	0	0	0	58.00
60.00	06000	LABORATORY	393,402	0	54,104	362	18,970	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	60,653	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	195,922	0	126,461	10,904	44,339	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,638	0	8,002	0	2,805	67.00
68.00	06800	SPEECH PATHOLOGY	7,614	0	997	0	349	68.00
69.00	06900	ELECTROCARDIOLOGY	106,948	0	47,298	2,871	16,583	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,138	0	100,463	0	35,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,668	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	609,117	0	31,637	0	11,092	73.00
76.00	03950	DIABETIC SERVICES	36,862	0	34,997	0	12,270	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,015,043	0	446,072	0	156,400	88.00
91.00	09100	EMERGENCY	588,328	0	174,301	38,437	61,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,621,250	0	1,898,883	136,321	654,139	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	22,405	0	78,536	3,350	27,536	192.00
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)	6,643,655	0	1,977,419	139,671	681,675	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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	1,017,552					10.00
11.00	01100	CAFETERIA	829,293	829,293				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,715	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	10,147	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	188,259	111,906	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	35,224	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,175	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,144	0	0	0	54.00
56.00	05600	RADIOTISOTOPE	0	2,899	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	65,810	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	16,525	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,862	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,320	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,305	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,381	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,366	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	6,088	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	301,437	0	0	0	88.00
91.00	09100	EMERGENCY	0	92,989	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,017,552	829,293	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	1,017,552	829,293	0	0	0	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	432,099				16.00
17.00	01700	SOCIAL SERVICE	0	0	432,950			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	16,498	432,950	3,323,080	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,351	0	1,323,233	0	50.00
53.00	05300	ANESTHESIOLOGY	0	5,642	0	98,069	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,025	0	1,993,514	0	54.00
56.00	05600	RADIOISOTOPE	0	5,318	0	105,873	0	56.00
57.00	05700	CT SCAN	0	48,103	0	50,050	0	57.00
58.00	05800	MRI	0	15,073	0	338,962	0	58.00
60.00	06000	LABORATORY	0	80,110	0	1,778,676	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	4,522	0	261,456	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,700	0	1,009,839	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,899	0	206,883	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	580	0	33,410	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,087	0	530,129	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,116	0	615,539	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,089	0	63,192	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55,182	0	2,512,258	0	73.00
76.00	03950	DIABETIC SERVICES	0	200	0	199,664	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	42,046	0	8,932,940	0	88.00
91.00	09100	EMERGENCY	0	59,558	0	2,758,343	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	432,099	432,950	26,135,110	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	198,227	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	432,099	432,950	26,333,337	0	202.00

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Cost Center Description		Total	
		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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
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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	503,384	220,458	188,541	912,383	0 5.00
6.00	00600	MAINTENANCE & REPAIRS	216	0	0	216	0 6.00
7.00	00700	OPERATION OF PLANT	0	143,269	122,526	265,795	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	0	15,119	12,930	28,049	0 9.00
10.00	01000	DIETARY	0	85,624	73,227	158,851	0 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,516	19,256	41,772	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	137,585	117,665	255,250	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	69,597	59,521	129,118	0 50.00
53.00	05300	ANESTHESIOLOGY	0	2,998	2,564	5,562	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,455	65,120	55,692	202,267	0 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	34,677	24,657	21,087	80,421	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	263	0	0	263	0 65.00
66.00	06600	PHYSICAL THERAPY	0	57,632	49,288	106,920	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,647	3,119	6,766	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	454	388	842	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,555	18,434	39,989	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,784	39,155	84,939	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,418	12,330	26,748	0 73.00
76.00	03950	DIABETIC SERVICES	0	15,949	13,640	29,589	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	203,289	173,857	377,146	0 88.00
91.00	09100	EMERGENCY	0	79,434	67,933	147,367	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	619,995	1,229,105	1,051,153	2,900,253	0 118.00
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	35,791	30,609	66,400	0 192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	619,995	1,264,896	1,081,762	2,966,653	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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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	912,383					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	216				6.00
7.00	00700	OPERATION OF PLANT	68,512	31	334,338			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,839	0	0	4,839		8.00
9.00	00900	HOUSEKEEPING	22,469	3	5,609	0	56,130	9.00
10.00	01000	DIETARY	26,463	18	31,767	0	5,424	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,803	5	8,353	0	1,426	16.00
17.00	01700	SOCIAL SERVICE	14,649	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,450	29	51,045	1,585	8,716	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,327	15	25,821	448	4,409	50.00
53.00	05300	ANESTHESIOLOGY	2,646	1	1,112	0	190	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,872	14	24,160	868	4,125	54.00
56.00	05600	RADIOISOTOPE	3,384	0	0	0	0	56.00
57.00	05700	CT SCAN	67	0	0	0	0	57.00
58.00	05800	MRI	11,222	0	0	0	0	58.00
60.00	06000	LABORATORY	54,026	5	9,148	13	1,562	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,330	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	26,906	12	21,382	378	3,651	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,405	1	1,353	0	231	67.00
68.00	06800	SPEECH PATHOLOGY	1,046	0	169	0	29	68.00
69.00	06900	ELECTROCARDIOLOGY	14,687	5	7,997	99	1,365	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,812	10	16,986	0	2,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,152	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,651	3	5,349	0	913	73.00
76.00	03950	DIABETIC SERVICES	5,062	3	5,917	0	1,010	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	276,730	44	75,421	0	12,880	88.00
91.00	09100	EMERGENCY	80,796	17	29,470	1,332	5,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	909,306	216	321,059	4,723	53,863	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	3,077	0	13,279	116	2,267	192.00
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)	912,383	216	334,338	4,839	56,130	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
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	222,523				10.00
11.00	01100	CAFETERIA	181,354	181,354			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,405	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,219	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,169	24,472	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,703	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,569	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,121	0	0	54.00
56.00	05600	RADIOTISOTOPE	0	634	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	14,392	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,614	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,624	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,601	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	285	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,676	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,454	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	1,331	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	65,919	0	0	88.00
91.00	09100	EMERGENCY	0	20,335	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	222,523	181,354	0	0	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	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	222,523	181,354	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	68,764				16.00
17.00	01700	SOCIAL SERVICE	0	0	16,868			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,627	16,868	475,211	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,240	0	207,081	0	50.00
53.00	05300	ANESTHESIOLOGY	0	898	0	11,978	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,736	0	310,163	0	54.00
56.00	05600	RADIOISOTOPE	0	847	0	4,865	0	56.00
57.00	05700	CT SCAN	0	7,659	0	7,726	0	57.00
58.00	05800	MRI	0	2,400	0	13,622	0	58.00
60.00	06000	LABORATORY	0	12,720	0	172,287	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	720	0	12,927	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,659	0	169,532	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	621	0	16,978	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	92	0	2,463	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,880	0	71,698	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	496	0	125,597	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	173	0	2,325	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,786	0	125,450	0	73.00
76.00	03950	DIABETIC SERVICES	0	32	0	42,944	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	6,695	0	814,835	0	88.00
91.00	09100	EMERGENCY	0	9,483	0	293,832	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	68,764	16,868	2,881,514	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	85,139	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	68,764	16,868	2,966,653	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1

Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,470					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		97,470				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,310,761			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,988	16,988	1,223,740	-6,643,655	19,689,682	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	11,040	11,040	362,388	0	1,478,535	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	27,109	0	104,433	8.00
9.00	00900	HOUSEKEEPING	1,165	1,165	308,208	0	484,890	9.00
10.00	01000	DIETARY	6,598	6,598	272,932	0	571,096	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,735	1,735	153,700	0	254,712	16.00
17.00	01700	SOCIAL SERVICE	0	0	105,477	0	316,134	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,602	10,602	978,744	0	1,585,094	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,363	5,363	458,226	0	783,957	50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	0	57,101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	599,412	0	1,248,906	54.00
56.00	05600	RADIOISOTOPE	0	0	31,691	0	73,018	56.00
57.00	05700	CT SCAN	0	0	0	0	1,456	57.00
58.00	05800	MRI	0	0	0	0	242,175	58.00
60.00	06000	LABORATORY	1,900	1,900	479,857	0	1,165,918	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	132,140	0	179,756	65.00
66.00	06600	PHYSICAL THERAPY	4,441	4,441	339,946	0	580,651	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	93,068	0	138,219	67.00
68.00	06800	SPEECH PATHOLOGY	35	35	14,990	0	22,565	68.00
69.00	06900	ELECTROCARDIOLOGY	1,661	1,661	198,577	0	316,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,528	3,528	0	0	341,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	46,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	220,963	0	1,805,230	73.00
76.00	03950	DIABETIC SERVICES	1,229	1,229	58,663	0	109,247	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,665	15,665	3,286,594	0	5,971,942	88.00
91.00	09100	EMERGENCY	6,121	6,121	964,336	0	1,743,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,712	94,712	10,310,761	-6,643,655	19,623,282	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	2,758	2,758	0	0	66,400	192.00
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)	1,264,896	1,081,762	3,484,047		6,643,655	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.977285	11.098410	0.337904		0.337418	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		912,383	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.046338	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: 14-1318

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

Worksheet B-1

Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			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	77,724					6.00
7.00	00700	OPERATION OF PLANT	11,040	69,442				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	89,468			8.00
9.00	00900	HOUSEKEEPING	1,165	1,165	0	68,277		9.00
10.00	01000	DIETARY	6,598	6,598	0	6,598	30,117	10.00
11.00	01100	CAFETERIA	0	0	0	0	24,545	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,735	1,735	0	1,735	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,602	10,602	29,327	10,602	5,572	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,363	5,363	8,276	5,363	0	50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	231	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	16,042	5,018	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,900	1,900	232	1,900	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,441	4,441	6,985	4,441	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	0	281	0	67.00
68.00	06800	SPEECH PATHOLOGY	35	35	0	35	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,661	1,661	1,839	1,661	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,528	3,528	0	3,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	0	1,111	0	73.00
76.00	03950	DIABETIC SERVICES	1,229	1,229	0	1,229	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,665	15,665	0	15,665	0	88.00
91.00	09100	EMERGENCY	6,121	6,121	24,621	6,121	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,724	66,684	87,322	65,519	30,117	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	2,758	2,146	2,758	0	192.00
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)	0	1,977,419	139,671	681,675	1,017,552	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	28.475836	1.561128	9.983962	33.786632	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	216	334,338	4,839	56,130	222,523	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002779	4.814637	0.054086	0.822092	7.388618	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: 14-1318

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

Worksheet B-1

Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description			CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
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	11,442					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	341	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	140	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,544	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	486	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	99	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	954	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	40	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	908	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	228	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	481	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	101	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	295	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	281	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	84	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,159	0	0	0	0	88.00
91.00	09100	EMERGENCY	1,283	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,442	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	829,293	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	72.477976	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	181,354	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	15.849851	0.000000	0.000000	0.000000	0.000000	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: 14-1318

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

Worksheet B-1

Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		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		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	71,739,911	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,739,147	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,378,946	50.00
53.00	05300	ANESTHESIOLOGY	936,813	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,981,218	54.00
56.00	05600	RADIOISOTOPE	882,967	56.00
57.00	05700	CT SCAN	7,986,561	57.00
58.00	05800	MRI	2,502,563	58.00
60.00	06000	LABORATORY	13,299,109	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	750,745	65.00
66.00	06600	PHYSICAL THERAPY	2,772,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	647,324	67.00
68.00	06800	SPEECH PATHOLOGY	96,312	68.00
69.00	06900	ELECTROCARDIOLOGY	3,003,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	517,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	180,832	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,161,859	73.00
76.00	03950	DIABETIC SERVICES	33,164	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	6,980,882	88.00
91.00	09100	EMERGENCY	9,888,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,739,911	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
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)	432,099	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006023	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,764	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000959	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 1:22 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,323,080		3,323,080	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,323,233		1,323,233	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	98,069		98,069	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,993,514		1,993,514	0	0	54.00	
56.00	05600	RADIOISOTOPE	105,873		105,873	0	0	56.00	
57.00	05700	CT SCAN	50,050		50,050	0	0	57.00	
58.00	05800	MRI	338,962		338,962	0	0	58.00	
60.00	06000	LABORATORY	1,778,676		1,778,676	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	261,456	0	261,456	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,009,839	0	1,009,839	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	206,883	0	206,883	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	33,410	0	33,410	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	530,129		530,129	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	615,539		615,539	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,192		63,192	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,512,258		2,512,258	0	0	73.00	
76.00	03950	DIABETIC SERVICES	199,664		199,664	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	8,932,940		8,932,940	0	0	88.00	
91.00	09100	EMERGENCY	2,758,343		2,758,343	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	384,697		384,697	0	0	92.00	
200.00		Subtotal (see instructions)	26,519,807	0	26,519,807	0	0	200.00	
201.00		Less Observation Beds	384,697		384,697	0	0	201.00	
202.00		Total (see instructions)	26,135,110	0	26,135,110	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 1:22 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	2,377,148		2,377,148		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	109,972	3,268,974	3,378,946	0.391611	0.000000
53.00	05300	ANESTHESIOLOGY	28,155	908,658	936,813	0.104684	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,156	5,898,062	5,981,218	0.333296	0.000000
56.00	05600	RADIOISOTOPE	2,964	880,003	882,967	0.119906	0.000000
57.00	05700	CT SCAN	185,667	7,800,894	7,986,561	0.006267	0.000000
58.00	05800	MRI	34,688	2,467,875	2,502,563	0.135446	0.000000
60.00	06000	LABORATORY	883,273	12,415,836	13,299,109	0.133744	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	526,006	221,445	747,451	0.349797	0.000000
66.00	06600	PHYSICAL THERAPY	331,818	2,440,874	2,772,692	0.364209	0.000000
67.00	06700	OCCUPATIONAL THERAPY	94,442	552,882	647,324	0.319597	0.000000
68.00	06800	SPEECH PATHOLOGY	29,668	66,644	96,312	0.346893	0.000000
69.00	06900	ELECTROCARDIOLOGY	106,080	2,896,937	3,003,017	0.176532	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,231	516,382	520,613	1.182335	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	180,832	180,832	0.349451	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,259,009	7,902,850	9,161,859	0.274208	0.000000
76.00	03950	DIABETIC SERVICES	0	33,164	33,164	6.020504	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,980,882	6,980,882		88.00
91.00	09100	EMERGENCY	145,216	9,743,225	9,888,441	0.278946	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,695	334,304	361,999	1.062702	0.000000
200.00		Subtotal (see instructions)	6,229,188	65,510,723	71,739,911		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,229,188	65,510,723	71,739,911		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 1:22 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
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	DIABETIC SERVICES	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
2/28/2020 1:22 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 1:22 pm

			Title XIX			Hospital	PPS	
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	2,377,148		2,377,148			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	109,972	3,268,974	3,378,946	0.391611	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	28,155	908,658	936,813	0.104684	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,156	5,898,062	5,981,218	0.333296	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,964	880,003	882,967	0.119906	0.000000	56.00
57.00	05700	CT SCAN	185,667	7,800,894	7,986,561	0.006267	0.000000	57.00
58.00	05800	MRI	34,688	2,467,875	2,502,563	0.135446	0.000000	58.00
60.00	06000	LABORATORY	883,273	12,415,836	13,299,109	0.133744	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	526,006	221,445	747,451	0.349797	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	331,818	2,440,874	2,772,692	0.364209	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,442	552,882	647,324	0.319597	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	29,668	66,644	96,312	0.346893	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	106,080	2,896,937	3,003,017	0.176532	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,231	516,382	520,613	1.182335	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	180,832	180,832	0.349451	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,259,009	7,902,850	9,161,859	0.274208	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	33,164	33,164	6.020504	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,980,882	6,980,882	1.279629	0.000000	88.00
91.00	09100	EMERGENCY	145,216	9,743,225	9,888,441	0.278946	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,695	334,304	361,999	1.062702	0.000000	92.00
200.00		Subtotal (see instructions)	6,229,188	65,510,723	71,739,911			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,229,188	65,510,723	71,739,911			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.391611			50.00
53.00	05300 ANESTHESIOLOGY	0.104684			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.333296			54.00
56.00	05600 RADIOISOTOPE	0.119906			56.00
57.00	05700 CT SCAN	0.006267			57.00
58.00	05800 MRI	0.135446			58.00
60.00	06000 LABORATORY	0.133744			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.349797			65.00
66.00	06600 PHYSICAL THERAPY	0.364209			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.319597			67.00
68.00	06800 SPEECH PATHOLOGY	0.346893			68.00
69.00	06900 ELECTROCARDIOLOGY	0.176532			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.182335			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.349451			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.274208			73.00
76.00	03950 DIABETIC SERVICES	6.020504			76.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.279629			88.00
91.00	09100 EMERGENCY	0.278946			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.062702			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part II
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,323,233	207,081	1,116,152	0	0
53.00	05300	ANESTHESIOLOGY	98,069	11,978	86,091	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,993,514	310,163	1,683,351	0	0
56.00	05600	RADIOISOTOPE	105,873	4,865	101,008	0	0
57.00	05700	CT SCAN	50,050	7,726	42,324	0	0
58.00	05800	MRI	338,962	13,622	325,340	0	0
60.00	06000	LABORATORY	1,778,676	172,287	1,606,389	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	261,456	12,927	248,529	0	0
66.00	06600	PHYSICAL THERAPY	1,009,839	169,532	840,307	0	0
67.00	06700	OCCUPATIONAL THERAPY	206,883	16,978	189,905	0	0
68.00	06800	SPEECH PATHOLOGY	33,410	2,463	30,947	0	0
69.00	06900	ELECTROCARDIOLOGY	530,129	71,698	458,431	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	615,539	125,597	489,942	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,192	2,325	60,867	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,512,258	125,450	2,386,808	0	0
76.00	03950	DIABETIC SERVICES	199,664	42,944	156,720	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,932,940	814,835	8,118,105	0	0
91.00	09100	EMERGENCY	2,758,343	293,832	2,464,511	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	384,697	55,013	329,684	0	0
200.00		Subtotal (sum of lines 50 thru 199)	23,196,727	2,461,316	20,735,411	0	0
201.00		Less Observation Beds	384,697	55,013	329,684	0	0
202.00		Total (line 200 minus line 201)	22,812,030	2,406,303	20,405,727	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part II
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,323,233	3,378,946	0.391611	50.00
53.00	05300	ANESTHESIOLOGY	98,069	936,813	0.104684	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,993,514	5,981,218	0.333296	54.00
56.00	05600	RADIOISOTOPE	105,873	882,967	0.119906	56.00
57.00	05700	CT SCAN	50,050	7,986,561	0.006267	57.00
58.00	05800	MRI	338,962	2,502,563	0.135446	58.00
60.00	06000	LABORATORY	1,778,676	13,299,109	0.133744	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	261,456	747,451	0.349797	65.00
66.00	06600	PHYSICAL THERAPY	1,009,839	2,772,692	0.364209	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,883	647,324	0.319597	67.00
68.00	06800	SPEECH PATHOLOGY	33,410	96,312	0.346893	68.00
69.00	06900	ELECTROCARDIOLOGY	530,129	3,003,017	0.176532	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	615,539	520,613	1.182335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,192	180,832	0.349451	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,512,258	9,161,859	0.274208	73.00
76.00	03950	DIABETIC SERVICES	199,664	33,164	6.020504	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,932,940	6,980,882	1.279629	88.00
91.00	09100	EMERGENCY	2,758,343	9,888,441	0.278946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	384,697	361,999	1.062702	92.00
200.00		Subtotal (sum of lines 50 thru 199)	23,196,727	69,362,763		200.00
201.00		Less Observation Beds	384,697	0		201.00
202.00		Total (line 200 minus line 201)	22,812,030	69,362,763		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/28/2020 1:22 pm			
				Title XVIII		Hospital		Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	207,081	3,378,946	0.061286	6,192	379	50.00	
53.00	05300	ANESTHESIOLOGY	11,978	936,813	0.012786	2,120	27	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,163	5,981,218	0.051856	25,062	1,300	54.00	
56.00	05600	RADIOISOTOPE	4,865	882,967	0.005510	0	0	56.00	
57.00	05700	CT SCAN	7,726	7,986,561	0.000967	57,010	55	57.00	
58.00	05800	MRI	13,622	2,502,563	0.005443	14,000	76	58.00	
60.00	06000	LABORATORY	172,287	13,299,109	0.012955	292,817	3,793	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	12,927	747,451	0.017295	180,750	3,126	65.00	
66.00	06600	PHYSICAL THERAPY	169,532	2,772,692	0.061143	68,704	4,201	66.00	
67.00	06700	OCCUPATIONAL THERAPY	16,978	647,324	0.026228	9,572	251	67.00	
68.00	06800	SPEECH PATHOLOGY	2,463	96,312	0.025573	9,683	248	68.00	
69.00	06900	ELECTROCARDIOLOGY	71,698	3,003,017	0.023875	62,190	1,485	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,597	520,613	0.241248	937	226	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,325	180,832	0.012857	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	125,450	9,161,859	0.013693	359,831	4,927	73.00	
76.00	03950	DIABETIC SERVICES	42,944	33,164	1.294898	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	814,835	6,980,882	0.116724	0	0	88.00	
91.00	09100	EMERGENCY	293,832	9,888,441	0.029715	1,332	40	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	55,013	361,999	0.151970	0	0	92.00	
200.00		Total (lines 50 through 199)	2,461,316	69,362,763		1,090,200	20,134	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

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

Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
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)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1318		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 1:22 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	0	3,378,946	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	936,813	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	5,981,218	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	882,967	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	7,986,561	0.000000	57.00
58.00	05800	MRI	0	0	0	0	2,502,563	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	13,299,109	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	747,451	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,772,692	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	647,324	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	96,312	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3,003,017	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	520,613	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	180,832	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,161,859	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	33,164	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	6,980,882	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	0	9,888,441	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	361,999	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	69,362,763		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	6,192	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,120	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	25,062	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	57,010	0	0	0	57.00
58.00	05800	MRI	0.000000	14,000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	292,817	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	180,750	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	68,704	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	9,572	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,683	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	62,190	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	937	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	359,831	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	1,332	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)		1,090,200	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST					Provider CCN: 14-1318		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part V Date/Time Prepared: 2/28/2020 1:22 pm	
					Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	0.391611	0	985,416	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.104684	0	273,463	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333296	0	1,678,874	0	0	0	54.00	
56.00	05600	RADIOISOTOPE	0.119906	0	275,448	0	0	0	56.00	
57.00	05700	CT SCAN	0.006267	0	2,391,452	0	0	0	57.00	
58.00	05800	MRI	0.135446	0	742,256	0	0	0	58.00	
60.00	06000	LABORATORY	0.133744	0	4,132,652	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.349797	0	88,194	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.364209	0	761,851	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.319597	0	101,781	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.346893	0	9,882	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.176532	0	978,871	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.182335	0	184,023	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.349451	0	61,956	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.274208	0	3,689,503	3,826	0	0	73.00	
76.00	03950	DIABETIC SERVICES	6.020504	0	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00	
91.00	09100	EMERGENCY	0.278946	0	2,656,452	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.062702	0	167,855	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	19,179,929	3,826	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program			0	0	0	0	201.00	
202.00		Net Charges (line 200 - line 201)		0	19,179,929	3,826	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1318		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part V Date/Time Prepared: 2/28/2020 1:22 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	385,900		0				50.00
53.00	05300	ANESTHESIOLOGY	28,627		0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	559,562		0				54.00
56.00	05600	RADIOISOTOPE	33,028		0				56.00
57.00	05700	CT SCAN	14,987		0				57.00
58.00	05800	MRI	100,536		0				58.00
60.00	06000	LABORATORY	552,717		0				60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0				62.30
65.00	06500	RESPIRATORY THERAPY	30,850		0				65.00
66.00	06600	PHYSICAL THERAPY	277,473		0				66.00
67.00	06700	OCCUPATIONAL THERAPY	32,529		0				67.00
68.00	06800	SPEECH PATHOLOGY	3,428		0				68.00
69.00	06900	ELECTROCARDIOLOGY	172,802		0				69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	217,577		0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,651		0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,011,691		1,049				73.00
76.00	03950	DIABETIC SERVICES	0		0				76.00
76.97	07697	CARDIAC REHABILITATION	0		0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0				76.98
76.99	07699	LITHOTRIPSY	0		0				76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0				88.00
91.00	09100	EMERGENCY	741,007		0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	178,380		0				92.00
200.00		Subtotal (see instructions)	4,362,745		1,049				200.00
201.00		Less PBP Clinic Lab. Services-Program	0						201.00
		Only Charges							
202.00		Net Charges (line 200 - line 201)	4,362,745		1,049				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST					Provider CCN: 14-1318 Component CCN: 14-Z318		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part V Date/Time Prepared: 2/28/2020 1:22 pm	
					Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	0.391611	0	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.104684	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333296	0	0	0	0	0	54.00	
56.00	05600	RADIOISOTOPE	0.119906	0	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.006267	0	0	0	0	0	57.00	
58.00	05800	MRI	0.135446	0	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.133744	0	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.349797	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.364209	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.319597	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.346893	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.176532	0	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.182335	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.349451	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.274208	0	0	0	0	0	73.00	
76.00	03950	DIABETIC SERVICES	6.020504	0	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00	
91.00	09100	EMERGENCY	0.278946	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.062702	0	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	0	0	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program			0	0	0	0	201.00	
		Only Charges								
202.00		Net Charges (line 200 - line 201)		0	0	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1318

Period:

Worksheet D

Component CCN: 14-Z318

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/28/2020 1:22 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
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	DIABETIC SERVICES	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		475,211	205,213	269,998	746	361.93	30.00
200.00	Total (lines 30 through 199)		475,211		269,998	746		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		31	11,220				
200.00	Total (lines 30 through 199)		31	11,220				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description			Title XIX		Hospital	PPS	
			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	207,081	3,378,946	0.061286	0	0 50.00
53.00	05300	ANESTHESIOLOGY	11,978	936,813	0.012786	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,163	5,981,218	0.051856	0	0 54.00
56.00	05600	RADIOISOTOPE	4,865	882,967	0.005510	0	0 56.00
57.00	05700	CT SCAN	7,726	7,986,561	0.000967	0	0 57.00
58.00	05800	MRI	13,622	2,502,563	0.005443	0	0 58.00
60.00	06000	LABORATORY	172,287	13,299,109	0.012955	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	12,927	747,451	0.017295	0	0 65.00
66.00	06600	PHYSICAL THERAPY	169,532	2,772,692	0.061143	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	16,978	647,324	0.026228	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	2,463	96,312	0.025573	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	71,698	3,003,017	0.023875	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,597	520,613	0.241248	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,325	180,832	0.012857	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,450	9,161,859	0.013693	0	0 73.00
76.00	03950	DIABETIC SERVICES	42,944	33,164	1.294898	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	814,835	6,980,882	0.116724	0	0 88.00
91.00	09100	EMERGENCY	293,832	9,888,441	0.029715	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	55,013	361,999	0.151970	0	0 92.00
200.00		Total (lines 50 through 199)	2,461,316	69,362,763		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1318		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/28/2020 1:22 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	746	0.00	31	30.00			
200.00		Total (lines 30 through 199)	0	0	746		31	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1318		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 1:22 pm	
			Title XIX		Hospital		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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 1:22 pm

			Title XIX		Hospital	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	3,378,946	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	936,813	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,981,218	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	882,967	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	7,986,561	0.000000	57.00
58.00	05800	MRI	0	0	0	2,502,563	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	13,299,109	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	747,451	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,772,692	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	647,324	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	96,312	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,003,017	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	520,613	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	180,832	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,161,859	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	33,164	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,980,882	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	9,888,441	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	361,999	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	69,362,763		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description		Title XIX			Hospital		PPS	
		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	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	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)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 1:22 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,428 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			746 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)			594 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			142 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)			425 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			29 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)			86 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			347 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)			126 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)			379 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)		3,323,080	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)		1,435,026	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,888,054	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)		1,888,054	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)		2,530.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		878,226	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)		878,226	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

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

Worksheet D-1

Date/Time Prepared:
2/28/2020 1:22 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)					258,211	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,136,437	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)					318,895	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					959,215	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,278,110	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)					152	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,530.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					384,697	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

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

Worksheet D-1

Date/Time Prepared:
2/28/2020 1:22 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	475,211	3,323,080	0.143003	384,697	55,013
91.00	Nursing School cost	0	3,323,080	0.000000	384,697	0
92.00	Allied health cost	0	3,323,080	0.000000	384,697	0
93.00	All other Medical Education	0	3,323,080	0.000000	384,697	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 1:22 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,428 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			746 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)			594 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)			567 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			29 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)			86 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			31 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)		3,323,080	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)		1,435,026	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,888,054	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)		1,888,054	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)		2,530.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		78,458	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)		78,458	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

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

Worksheet D-1

Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description		Title XIX		Hospital	PPS		
		Total	Total	Average Per	Program Days		Program Cost
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			(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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					78,458	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)					11,220	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)					11,220	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					67,238	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)					152	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,530.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					384,697	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

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

Worksheet D-1

Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description		Title XIX		Hospital	PPS	
		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	475,211	3,323,080	0.143003	384,697	55,013
91.00	Nursing School cost	0	3,323,080	0.000000	384,697	0
92.00	Allied health cost	0	3,323,080	0.000000	384,697	0
93.00	All other Medical Education	0	3,323,080	0.000000	384,697	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 1:22 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		600,714		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.391611	6,192	2,425	50.00
53.00	05300 ANESTHESIOLOGY	0.104684	2,120	222	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.333296	25,062	8,353	54.00
56.00	05600 RADIOISOTOPE	0.119906	0	0	56.00
57.00	05700 CT SCAN	0.006267	57,010	357	57.00
58.00	05800 MRI	0.135446	14,000	1,896	58.00
60.00	06000 LABORATORY	0.133744	292,817	39,163	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.349797	180,750	63,226	65.00
66.00	06600 PHYSICAL THERAPY	0.364209	68,704	25,023	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.319597	9,572	3,059	67.00
68.00	06800 SPEECH PATHOLOGY	0.346893	9,683	3,359	68.00
69.00	06900 ELECTROCARDIOLOGY	0.176532	62,190	10,979	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.182335	937	1,108	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.349451	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.274208	359,831	98,669	73.00
76.00	03950 DIABETIC SERVICES	6.020504	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.278946	1,332	372	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.062702	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,090,200	258,211	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,090,200		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318 Component CCN: 14-Z318	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 1:22 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.391611	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.104684	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.333296	11,205	3,735	54.00
56.00	05600 RADIOISOTOPE	0.119906	0	0	56.00
57.00	05700 CT SCAN	0.006267	3,327	21	57.00
58.00	05800 MRI	0.135446	5,222	707	58.00
60.00	06000 LABORATORY	0.133744	163,483	21,865	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.349797	155,734	54,475	65.00
66.00	06600 PHYSICAL THERAPY	0.364209	160,651	58,511	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.319597	52,207	16,685	67.00
68.00	06800 SPEECH PATHOLOGY	0.346893	8,843	3,068	68.00
69.00	06900 ELECTROCARDIOLOGY	0.176532	790	139	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.182335	142	168	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.349451	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.274208	358,431	98,285	73.00
76.00	03950 DIABETIC SERVICES	6.020504	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.278946	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.062702	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		920,035	257,659	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		920,035		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/28/2020 1:22 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,363,794 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)			4,363,794 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)			4,407,432 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)			47,945 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			3,018,931 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)			1,340,556 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)			1,340,556 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			1,340,556 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)			432,653 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			281,224 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			1,621,780 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			1,621,780 40.00
40.01	Sequestration adjustment (see instructions)			32,436 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			1,500,667 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			88,677 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/28/2020 1:22 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		933,866		1,454,151	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/05/2019	47,862	05/05/2019	8,115	3.01
3.02		09/03/2019	8,284	09/03/2019	38,401	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)		56,146		46,516	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)		990,012		1,500,667	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		22,823		88,677	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,012,835		1,589,344	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: 14-1318

Period:

Worksheet E-1

Component CCN: 14-Z318

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/28/2020 1:22 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,303,224		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	05/15/2019	73,785		0	3.01
3.02		09/03/2019	13,792		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)		87,577		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,390,801		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		116,127		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,506,928		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: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/28/2020 1:22 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: 14-1318 Component CCN: 14-Z318	Period: From 10/01/2018 To 09/30/2019	Worksheet E-2 Date/Time Prepared: 2/28/2020 1:22 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,290,891	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)	260,236	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	505	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,551,127	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,551,127	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,551,127	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,445	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,537,682	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,537,682	0	19.00
19.01	Sequestration adjustment (see instructions)	30,754	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,390,801	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)	116,127	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: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/28/2020 1:22 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,136,437	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)		1,136,437	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,147,801	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)		1,147,801	19.00
20.00	Deductibles (exclude professional component)		137,140	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,010,661	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,010,661	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		35,144	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		22,844	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,033,505	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)		1,033,505	30.00
30.01	Sequestration adjustment (see instructions)		20,670	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		990,012	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)		22,823	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1318

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

Worksheet G

Date/Time Prepared:
2/28/2020 1:22 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	349,835	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	11,277,899	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,644,684	0	0	0	6.00
7.00	Inventory	344,555	0	0	0	7.00
8.00	Prepaid expenses	42,919	0	0	0	8.00
9.00	Other current assets	625,948	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)	6,996,472	0	0	0	11.00
FIXED ASSETS						
12.00	Land	325,000	0	0	0	12.00
13.00	Land improvements	369,733	0	0	0	13.00
14.00	Accumulated depreciation	-260,011	0	0	0	14.00
15.00	Buildings	19,220,858	0	0	0	15.00
16.00	Accumulated depreciation	-5,369,270	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	8,002,667	0	0	0	23.00
24.00	Accumulated depreciation	-4,613,082	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	256,663	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,932,558	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	21,824,397	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	6,631,798	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	28,456,195	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	53,385,225	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	649,902	0	0	0	37.00
38.00	Salaries, wages, and fees payable	836,284	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	18,750	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	3,102	0	0	0	43.00
44.00	Other current liabilities	352,193	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,860,231	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	196,794	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	196,794	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,057,025	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	51,328,200				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)	51,328,200	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	53,385,225	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1318

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

Worksheet G-1

Date/Time Prepared:
2/28/2020 1:22 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		44,739,302		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,642,282				2.00
3.00	Total (sum of line 1 and line 2)		52,381,584		0		3.00
4.00	Additions (OTHER)	5,336		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)		5,336		0		10.00
11.00	Subtotal (line 3 plus line 10)		52,386,920		0		11.00
12.00	ASSETS RELEASED	603,046		0		0	12.00
13.00	EQUITY TRANSFER	-8,391		0		0	13.00
14.00	EQUITY TRANSFER	464,065		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)		1,058,720		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		51,328,200		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (OTHER)		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	ASSETS RELEASED		0				12.00
13.00	EQUITY TRANSFER		0				13.00
14.00	EQUITY TRANSFER		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: 14-1318

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2020 1:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,377,148		2,377,148	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,377,148		2,377,148	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,377,148		2,377,148	17.00
18.00	Ancillary services	3,679,129	48,446,869	52,125,998	18.00
19.00	Outpatient services	172,911	10,073,722	10,246,633	19.00
20.00	RURAL HEALTH CLINIC	0	6,980,882	6,980,882	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	PROFESSIONAL FEES	64,247	4,302,828	4,367,075	27.00
27.01	OTHER NRCC	0	9,250	9,250	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,293,435	69,813,551	76,106,986	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,299,405		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,299,405		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1318

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

Worksheet G-3

Date/Time Prepared:
2/28/2020 1:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	76,106,986	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,245,841	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,861,145	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,299,405	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,561,740	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	756,383	6.00
7.00	Income from investments	987,984	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	81,250	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	58,680	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	4,354	16.00
17.00	Revenue from sale of drugs to other than patients	991,611	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	3,582	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER GRANT INCOME	196,698	24.00
25.00	Total other income (sum of lines 6-24)	3,080,542	25.00
26.00	Total (line 5 plus line 25)	7,642,282	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)	7,642,282	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period:

Worksheet M-1

Component CCN: 14-3461

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 1:22 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	815,761	195,548	1,011,309	-195,548	815,761
2.00	Physician Assistant	440,186	105,518	545,704	-105,518	440,186
3.00	Nurse Practitioner	277,714	66,572	344,286	-66,572	277,714
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	769,354	184,423	953,777	-184,423	769,354
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	123,796	29,675	153,471	-29,675	123,796
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	189,702	45,474	235,176	-45,474	189,702
10.00	Subtotal (sum of lines 1 through 9)	2,616,513	627,210	3,243,723	-627,210	2,616,513
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	34,029	34,029	-27,818	6,211
16.00	Transportation (Health Care Staff)	0	15,054	15,054	0	15,054
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	35,890	35,890	0	35,890
19.00	Other Health Care Costs	0	1,116,719	1,116,719	0	1,116,719
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	1,201,692	1,201,692	-27,818	1,173,874
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,616,513	1,828,902	4,445,415	-655,028	3,790,387
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	201,108	201,108	-201,108	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	201,108	201,108	-201,108	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	670,082	389,629	1,059,711	-365,854	693,857
31.00	Total Facility Overhead (sum of lines 29 and 30)	670,082	389,629	1,059,711	-365,854	693,857
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,286,595	2,419,639	5,706,234	-1,221,990	4,484,244

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period:

Worksheet M-1

Component CCN: 14-3461

From 10/01/2018

To 09/30/2019

Date/Time Prepared:

2/28/2020 1:22 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	815,761		1.00
2.00	Physician Assistant	0	440,186		2.00
3.00	Nurse Practitioner	0	277,714		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	769,354		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	123,796		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	189,702		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,616,513		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	6,211		15.00
16.00	Transportation (Health Care Staff)	0	15,054		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	35,890		18.00
19.00	Other Health Care Costs	0	1,116,719		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,173,874		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,790,387		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	0	0		29.00
30.00	Administrative Costs	0	693,857		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	693,857		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,484,244		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1318 Component CCN: 14-3461		Period: From 10/01/2018 To 09/30/2019		Worksheet M-2 Date/Time Prepared: 2/28/2020 1:22 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		2.89	10,785	4,200	12,138		1.00
2.00	Physician Assistant		2.08	14,128	2,100	4,368		2.00
3.00	Nurse Practitioner		2.56	4,185	2,100	5,376		3.00
4.00	Subtotal (sum of lines 1 through 3)		7.53	29,098		21,882	29,098	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		1.96	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)		0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)		0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)		9.49	29,098			29,098	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)						3,790,387	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)						3,790,387	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)						693,857	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						4,448,696	15.00
16.00	Total overhead (sum of lines 14 and 15)						5,142,553	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						5,142,553	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						5,142,553	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						8,932,940	20.00

Health Financial Systems		OSF HOLY FAMILY MED CTR		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1318	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN: 14-3461		Date/Time Prepared: 2/28/2020 1:22 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)			8,932,940	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			294,016	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,638,924	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			29,098	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)			29,098	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			296.89	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		296.89	296.89	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,536	4,612	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		456,023	1,369,257	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,825,280	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,284,585	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			1,912	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,716	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			1,370,955	16.04
16.05	Total program cost (see instructions)		0	1,373,671	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			108,870	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			234,761	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,373,671	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			76,082	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,449,753	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			1,449,753	26.00
26.01	Sequestration adjustment (see instructions)			28,995	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,186,700	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)			234,058	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: 14-1318 Component CCN: 14-3461	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 1:22 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,616,513	2,616,513	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002291	0.010493	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		5,994	27,455	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		61,038	30,267	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		67,032	57,722	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,790,387	3,790,387	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		5,142,553	5,142,553	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.017685	0.015229	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		90,946	78,316	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		157,978	136,038	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		445	2,038	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		355.01	66.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		125	475	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		44,376	31,706	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)			294,016	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)			76,082	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 1:22 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,186,700	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,186,700	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		234,058	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,420,758	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00