

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/22/2021 3:02 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/22/2021	Time: 3:02 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MENDOTA COMMUNITY HOSPITAL (14-1310) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

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	-139,004	-299,825	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	-107,375	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		132,251		0	10.00
200.00	Total	0	-246,379	-167,574	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/22/2021 3:02 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1401 EAST 12TH ST			PO Box:					1.00	
2.00	City: MENDOTA			State: IL		Zip Code: 61342-9216		County: LA SALLE		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		MENDOTA COMMUNITY HOSPITAL - RHC	148535	99914		02/11/2015	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2019	09/30/2020		20.00
21.00	Type of Control (see instructions)						1			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/22/2021 3:02 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
				Urban/Rural S	Date of Geogr		
				1.00	2.00		
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
				Beginning:	Ending:		
				1.00	2.00		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
				Y/N	Y/N		
				1.00	2.00		
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
				V	XVIII	XIX	
				1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	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	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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/22/2021 3:02 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/22/2021 3:02 pm	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/22/2021 3:02 pm	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			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		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
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	Y	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
<u>Miscellaneous Cost Reporting Information</u>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	51,828	0	7,802	118.01		
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N			120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
<u>Transplant Center Information</u>							
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/22/2021 3:02 pm	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149006		140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131		141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:				142.00	
143.00	City: PEORIA	State: IL		Zip Code: 61603		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	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	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/22/2021 3:02 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part II Date/Time Prepared: 4/22/2021 3:02 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/14/2020	Y	12/14/2020		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/22/2021 3:02 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		Y		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/22/2021 3:02 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	24,071.11	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	24,071.11	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	7.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	24,078.11	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/22/2021 3:02 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)	708	25	1,026		1.00
2.00	HMO and other (see instructions)	83	0			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	874	0	981		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	169		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,582	25	2,176		7.00
8.00	INTENSIVE CARE UNIT	4	1	5		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,586	26	2,181	0.00	140.97
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RHC (CONSOLIDATED)	6,532	3,533	18,895	0.00	25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	40.32
27.00	Total (sum of lines 14-26)				0.00	0.00
28.00	Observation Bed Days		45	355		181.29
29.00	Ambulance Trips	0				27.00
30.00	Employee discount days (see instruction)			0		28.00
31.00	Employee discount days - IRF			0		29.00
32.00	Labor & delivery days (see instructions)	0	0	0		30.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		31.00
33.00	LTCH non-covered days	0				32.00
33.01	LTCH site neutral days and discharges	0				32.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/22/2021 3:02 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	214	8	314	1.00
2.00 HMO and other (see instructions)			26	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	214	8	314	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MENDOTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1310 Component CCN: 14-8535		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/22/2021 3:02 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	1405 E. 12TH ST.			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MENDOTA		IL 61342	2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
4.00	Source of Federal Funds				
5.00	Community Health Center (Section 330(d), PHS Act)				
6.00	Migrant Health Center (Section 329(d), PHS Act)				
7.00	Health Services for the Homeless (Section 340(d), PHS Act)				
8.00	Appalachian Regional Commission				
9.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	from
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)				
	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		2	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number	MENDOTA COMMUNITY HOSPITAL - RHC		148535	14.00
14.01		OSF MEDICAL GROUP WASHINGTON STREET		148567	14.01
		Y/N	V	XVIII	XIX
		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)				Total Visits
		County			
		4.00			
2.00	City, State, ZIP Code, County	LASALLE COUNTY		2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1310

Period:

Worksheet S-8

Component CCN: 14-8535

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/22/2021 3:02 pm

RHC I

Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)							
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
Facility hours of operations (1)							
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet S-10 Date/Time Prepared: 4/22/2021 3:02 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)			0.370229 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,591,043		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	9,478,200		6.00
7.00	Medicaid cost (line 1 times line 6)	3,509,105		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,918,062		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,918,062		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)	947,808	367,681	1,315,489 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	350,906	367,681	718,587 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)	350,906	367,681	718,587 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,540,469		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	269,277		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	414,272		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,126,197		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	561,946		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,280,533		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,198,595		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet A Date/Time Prepared: 4/22/2021 3:02 pm	
	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
			1.00	2.00	3.00	4.00	5.00		
	GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		198,357	198,357	137,347	335,704	1.00	
1.01	00101	CAP REL COSTS-OFFSITE MOBS		0	0	256	256	1.01	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		513,264	513,264	-98,448	414,816	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-191,657	602,365	410,708	2,651,267	3,061,975	4.00	
5.01	01140	BUSINESS OFFICE	0	22,111	22,111	0	22,111	5.01	
5.02	00550	DATA PROCESSING	0	25,032	25,032	1,138,881	1,163,913	5.02	
5.03	00570	ADMITTING	0	0	0	0	0	5.03	
5.04	00560	PURCHASING RECEIVING AND STORES	94,698	4,736	99,434	67,206	166,640	5.04	
5.05	00590	OTHER A&G	969,614	5,826,469	6,796,083	-1,058,270	5,737,813	5.05	
7.00	00700	OPERATION OF PLANT	292,902	1,071,001	1,363,903	-212,621	1,151,282	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,284	53,284	0	53,284	8.00	
9.00	00900	HOUSEKEEPING	380,888	155,835	536,723	-97,442	439,281	9.00	
10.00	01000	DIETARY	260,995	177,820	438,815	-330,122	108,693	10.00	
11.00	01100	CAFETERIA	0	0	0	270,989	270,989	11.00	
13.00	01300	NURSING ADMINISTRATION	39,307	6,044	45,351	77,522	122,873	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	73,923	14,479	88,402	-13,615	74,787	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	248,183	248,183	17.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,595,946	474,321	2,070,267	-227,003	1,843,264	30.00	
31.00	03100	INTENSIVE CARE UNIT	7,598	19,668	27,266	-1,921	25,345	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	347,016	466,878	813,894	-236,789	577,105	50.00	
51.00	05100	RECOVERY ROOM	206,946	75,395	282,341	-53,403	228,938	51.00	
53.00	05300	ANESTHESIOLOGY	504,368	77,594	581,962	-45,259	536,703	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,390	383,684	882,074	117,207	999,281	54.00	
56.00	05600	RADIOISOTOPE	4,666	170,883	175,549	-34,006	141,543	56.00	
57.00	05700	CT SCAN	152,238	62,999	215,237	-27,299	187,938	57.00	
58.00	05800	MRI	71,405	19,725	91,130	-13,071	78,059	58.00	
60.00	06000	LABORATORY	606,607	736,541	1,343,148	-121,756	1,221,392	60.00	
64.00	06400	INTRAVENOUS THERAPY	288,655	94,446	383,101	-66,502	316,599	64.00	
65.00	06500	RESPIRATORY THERAPY	416,439	162,867	579,306	-73,649	505,657	65.00	
66.00	06600	PHYSICAL THERAPY	512,904	115,481	628,385	-74,310	554,075	66.00	
67.00	06700	OCCUPATIONAL THERAPY	81,678	21,542	103,220	-15,311	87,909	67.00	
68.00	06800	SPEECH PATHOLOGY	35,184	9,134	44,318	-4,663	39,655	68.00	
69.00	06900	ELECTROCARDIOLOGY	113,673	39,931	153,604	-26,234	127,370	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-37,882	-37,882	159,741	121,859	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	209,775	2,556,351	2,766,126	41,538	2,807,664	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00	
76.00	03020	CANCER CARE CENTER	52,887	1,222	54,109	-1,035	53,074	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,625,224	1,538,734	4,163,958	-868,805	3,295,153	88.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	1,009,512	2,420,731	3,430,243	-187,098	3,243,145	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,021,249	1,021,249	-1,021,249	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,261,781	19,102,291	30,364,072	256	30,364,328	118.00	
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,538	39,538	0	39,538	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	150,261	61,986	212,247	-256	211,991	192.00	
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00	
194.01	07951	MARKETING	0	0	0	0	0	194.01	
194.02	07952	FOUNDATION	0	105,545	105,545	0	105,545	194.02	
200.00		TOTAL (SUM OF LINES 118 through 199)	11,412,042	19,309,360	30,721,402	0	30,721,402	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/22/2021 3:02 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	92,773	428,477	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	256	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	783,003	1,197,819	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-165,566	2,896,409	4.00
5.01	01140	BUSINESS OFFICE	-140	21,971	5.01
5.02	00550	DATA PROCESSING	0	1,163,913	5.02
5.03	00570	ADMITTING	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	513,159	679,799	5.04
5.05	00590	OTHER A&G	-2,405,356	3,332,457	5.05
7.00	00700	OPERATION OF PLANT	-2,184	1,149,098	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	53,284	8.00
9.00	00900	HOUSEKEEPING	0	439,281	9.00
10.00	01000	DIETARY	0	108,693	10.00
11.00	01100	CAFETERIA	-71,185	199,804	11.00
13.00	01300	NURSING ADMINISTRATION	225,929	348,802	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,766	67,021	16.00
17.00	01700	SOCIAL SERVICE	-111,663	136,520	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-152,326	1,690,938	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,345	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	577,105	50.00
51.00	05100	RECOVERY ROOM	0	228,938	51.00
53.00	05300	ANESTHESIOLOGY	-504,368	32,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,693	992,588	54.00
56.00	05600	RADIOISOTOPE	0	141,543	56.00
57.00	05700	CT SCAN	0	187,938	57.00
58.00	05800	MRI	0	78,059	58.00
60.00	06000	LABORATORY	-1,201	1,220,191	60.00
64.00	06400	INTRAVENOUS THERAPY	0	316,599	64.00
65.00	06500	RESPIRATORY THERAPY	0	505,657	65.00
66.00	06600	PHYSICAL THERAPY	0	554,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	87,909	67.00
68.00	06800	SPEECH PATHOLOGY	-8,530	31,125	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,177	125,193	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	121,859	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,203,798	1,603,866	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	53,074	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-67,000	3,228,153	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,220,595	2,022,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,315,684	26,048,644	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,538	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-206,463	5,528	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	0	194.01
194.02	07952	FOUNDATION	0	105,545	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,522,147	26,199,255	200.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet A-6
Date/Time Prepared:
4/22/2021 3:02 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS INTEREST EXPENSE					
1.00	OTHER A&G	5.05	0	1,021,249		1.00
	0		0	1,021,249		
	B - TO RECLASS COPIER LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,129		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00						4.00
	0		0	9,129		
	C - TO RECLASS BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,485,307		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
	0		0	2,485,307		
	D - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	186,279	84,710		1.00
	0		186,279	84,710		
	G - TO RECLASS PHY CLNC OFF EQPMT DPR					
1.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	256		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	108,655		2.00
	0		0	108,911		
	I - TO RECLASS AUTO & OTHER PROP INSUR					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,334		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28,692		2.00
	0		0	30,026		
	K - TO RECLASS IMPLANTS AND O2 EXP					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	159,741		1.00
	0		0	159,741		
	L - TO RECLASS DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	46,167		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
7.00		0.00	0	0		7.00
	0		0	46,167		
	O - TO RECLASS NURSING ADMIN SALARIES					
1.00	NURSING ADMINISTRATION	13.00	83,463	0		1.00
	TOTALS		83,463	0		
	P - TO RECLASS ADVERTISING EXPENSE					
1.00	OTHER A&G	5.05	0	82		1.00
	TOTALS		0	82		
	V - RHC PHYSICIAN HOSP COSTS					
1.00	ADULTS & PEDIATRICS	30.00	120,873	0		1.00
	0		120,873	0		

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/22/2021 3:02 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	X - UTILITY EXPENSE				
1.00	OPERATION OF PLANT	7.00	0	54,210	1.00
	0		0	54,210	
	Y - CLINICAL ENGINEERING DEPT				
1.00	LABORATORY	60.00	0	27,508	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	235,236	2.00
	0		0	262,744	
	Z - MINISTRY RECLASS				
1.00	OPERATION OF PLANT	7.00	0	65,691	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	39,700	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	195,986	3.00
4.00	PHYSICAL THERAPY	66.00	0	23,828	4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	4,445	5.00
6.00	SPEECH PATHOLOGY	68.00	0	1,885	6.00
7.00	PURCHASING RECEIVING AND STORES	5.04	0	91,359	7.00
8.00	DATA PROCESSING	5.02	0	1,138,881	8.00
9.00	SOCIAL SERVICE	17.00	0	248,183	9.00
	0		0	1,809,958	
500.00	Grand Total: Increases		390,615	6,072,234	500.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/22/2021 3:02 pm

	Decreases						4/22/2021 3:02 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,021,249	0		1.00
	0		0	1,021,249			
	B - TO RECLASS COPIER LEASE EXPENSE						
1.00	LABORATORY	60.00	0	8,356	10		1.00
2.00	SPEECH PATHOLOGY	68.00	0	161	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	612	0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES						4.00
	0		0	9,129			
	C - TO RECLASS BENEFITS						
1.00	PURCHASING RECEIVING AND STORES	5.04	0	24,153	0		1.00
2.00	OTHER A&G	5.05	0	179,237	0		2.00
3.00	OPERATION OF PLANT	7.00	0	69,778	0		3.00
4.00	HOUSEKEEPING	9.00	0	97,442	0		4.00
5.00	DIETARY	10.00	0	59,133	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	5,941	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	13,615	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	347,794	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	1,921	0		9.00
10.00	OPERATING ROOM	50.00	0	77,048	0		10.00
11.00	RECOVERY ROOM	51.00	0	53,403	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	45,259	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	118,029	0		13.00
14.00	RADIOISOTOPE	56.00	0	463	0		14.00
15.00	CT SCAN	57.00	0	24,496	0		15.00
16.00	MRI	58.00	0	13,071	0		16.00
17.00	LABORATORY	60.00	0	140,908	0		17.00
18.00	INTRAVENOUS THERAPY	64.00	0	66,289	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	73,649	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	98,138	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	19,756	0		21.00
22.00	SPEECH PATHOLOGY	68.00	0	6,387	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	23,569	0		23.00
24.00	DRUGS CHARGED TO PATIENTS	73.00	0	44,329	0		24.00
25.00	CANCER CARE CENTER	76.00	0	1,035	0		25.00
26.00	RURAL HEALTH CLINIC	88.00	0	693,110	0		26.00
27.00	EMERGENCY	91.00	0	187,098	0		27.00
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	256	0		28.00
	0		0	2,485,307			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	186,279	84,710	0		1.00
	0		186,279	84,710			
	G - TO RECLASS PHY CLNC OFF EQPMT DPR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	108,911	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	108,911			
	I - TO RECLASS AUTO & OTHER PROP INSUR						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	30,026	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	30,026			
	K - TO RECLASS IMPLANTS AND O2 EXP						
1.00	OPERATING ROOM	50.00	0	159,741	0		1.00
	0		0	159,741			
	L - TO RECLASS DRUGS						
1.00	OTHER A&G	5.05	0	6,943	0		1.00
2.00	RADIOISOTOPE	56.00	0	33,543	0		2.00
3.00	CT SCAN	57.00	0	2,803	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	213	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	2,665	0		5.00
7.00	ELECTROCARDIOLOGY			0	0		7.00
	0		0	46,167			
	O - TO RECLASS NURSING ADMIN SALARIES						
1.00	OTHER A&G	5.05	83,463	0	0		1.00
	TOTALS		83,463	0			
	P - TO RECLASS ADVERTISING EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	82	0		1.00
	TOTALS		0	82			
	V - RHC PHYSICIAN HOSP COSTS						
1.00	RURAL HEALTH CLINIC	88.00	120,873	0	0		1.00
	0		120,873	0			

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
4/22/2021 3:02 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	X - UTILITY EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	54,210	0		1.00
	0		0	54,210			
	Y - CLINICAL ENGINEERING DEPT						
1.00	OPERATION OF PLANT	7.00	0	262,744	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	262,744			
	Z - MINISTRY RECLASS						
1.00	OTHER A&G	5.05	0	1,809,958	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		0	1,809,958			
500.00	Grand Total: Decreases		390,615	6,072,234			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/22/2021 3:02 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,927,000	0	0	0	0	1.00	
2.00	Land Improvements	2,047,602	9,147	0	9,147	0	2.00	
3.00	Buildings and Fixtures	16,280,191	0	0	0	30,268	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	13,196,155	351,987	0	351,987	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	33,450,948	361,134	0	361,134	30,268	8.00	
9.00	Reconciling Items	30,268	0	0	0	30,268	9.00	
10.00	Total (line 8 minus line 9)	33,420,680	361,134	0	361,134	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,927,000	0				1.00	
2.00	Land Improvements	2,056,749	0				2.00	
3.00	Buildings and Fixtures	16,249,923	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	13,548,142	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	33,781,814	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	33,781,814	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/22/2021 3:02 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	198,357	0	0	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	513,264	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	711,621	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	198,357				1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	513,264				2.00
3.00	Total (sum of lines 1-2)	0	711,621				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	20,231,432	0	20,231,432	0.598886	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	2,240	0	2,240	0.000066	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	13,548,142	0	13,548,142	0.401048	0	2.00
3.00	Total (sum of lines 1-2)	33,781,814	0	33,781,814	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	421,126	-21,341	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	256	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,187,356	9,129	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,608,738	-12,212	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	28,692	0	0	428,477	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	256	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,334	0	0	1,197,819	2.00
3.00	Total (sum of lines 1-2)	0	30,026	0	0	1,626,552	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/22/2021 3:02 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 #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-OFFSITE MOBS (chapter 2)			0CAP REL COSTS-OFFSITE MOBS	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B		0OTHER A&G	5.05	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-21,341	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,878,080			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	265,726			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-70,272	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,766	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines	B	-913	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-OFFSITE MOBS			0CAP REL COSTS-OFFSITE MOBS	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			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		0OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/22/2021 3:02 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 #		
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-10	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-140	BUSINESS OFFICE	5.01	0	33.01
33.02	MISCELLANEOUS INCOME	B	-1,615	OTHER A&G	5.05	0	33.02
33.03	MISCELLANEOUS INCOME	B	-8,530	SPEECH PATHOLOGY	68.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-2,177	ELECTROCARDIOLOGY	69.00	0	33.04
33.05	340B EXPENSE	B	-1,203,798	DRUGS CHARGED TO PATIENTS	73.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-61,966	RURAL HEALTH CLINIC	88.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-622	OTHER A&G	5.05	0	33.07
33.08	DONATIONS	A	-9,000	OTHER A&G	5.05	0	33.08
33.09	INCOME TAXES	A	-7	OTHER A&G	5.05	0	33.09
33.10	INCOME TAXES	A	10	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	MOB PROPERTY TAXES	A	-21,562	OTHER A&G	5.05	0	33.11
33.12	MOB PROPERTY TAXES	A	-5,034	RURAL HEALTH CLINIC	88.00	0	33.12
33.13	COMMUNITY HEALTH EXPENSE - SALARY	A	-24,201	OTHER A&G	5.05	0	33.13
33.14	COMMUNITY HEALTH EXPENSE - OTHER	A	-1,730	OTHER A&G	5.05	0	33.14
33.15	COMMUNITY HEALTH BENEFIT EXPENSE	A	-6,484	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	LOBBYING EXPENSE	A	-13,079	OTHER A&G	5.05	0	33.16
33.17	CRNA BENEFIT EXPENSE	A	-62,074	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	PROVIDER TAX IDPA EXPENSE	A	-843,555	OTHER A&G	5.05	0	33.18
33.19	NON RHC PHYSICIAN BENEFITS	A	-91,061	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	ASSET RE-LIFING	A	31,703	CAP REL COSTS-BLDG & FIXT	1.00	9	33.20
33.21	ASSET RE-LIFING	A	749,172	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.21
33.22	ADVERTISING	A	-82	OTHER A&G	5.05	0	33.22
33.23	PROMPTCARE - SALARY	A	-144,753	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.23
33.24	PROMPTCARE - OTHER	A	-61,710	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.24
33.25	PROMPTCARE - BENEFITS	A	-6,989	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	UNEMPLOYMENT COMP	A	5,882	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	PHYSICIAN PT B BENEFITS	A	-4,840	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.27
33.28	INTERCOMPANY INTEREST EXPENSE	A	-1,021,249	OTHER A&G	5.05	11	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,522,147				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
4/22/2021 3:02 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	82,411	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	318,985	285,154	2.00
3.00	5.05	OTHER A&G	HO POOLED - ADMIN & GENERAL	2,653,878	3,122,728	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	195,986	195,986	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	157,962	157,962	3.02
3.03	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	23,828	23,828	3.03
3.04	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	4,445	4,445	3.04
3.05	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	1,885	1,885	3.05
3.06	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	125,381	125,381	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	147,089	148,284	3.07
3.08	60.00	LABORATORY	MINISTRY ALLOCATION	17,330	17,330	3.08
3.09	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	225,929	0	3.09
3.10	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	136,520	248,183	3.10
3.11	5.04	PURCHASING RECEIVING AND STO	HO FUNCTIONAL - ADMIN & GEN	1,433,414	920,255	3.11
4.00	5.05	OTHER A&G	RELATED PARTY SFI CVO	46,913	46,717	4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SFI EETS EQUIP	5,909	9,288	4.01
4.02	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SFI ETS	1,391	0	4.02
4.03	7.00	OPERATION OF PLANT	SFI HEALTHCARE TECHNOLOGY SV	51,923	54,107	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	SFI HEALTHCARE TECHNOLOGY SV	83,443	86,953	4.04
4.05	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	9,752	10,162	4.05
4.06	31.00	INTENSIVE CARE UNIT	EICU	979	979	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,725,353	5,459,627	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	0.00	OSF HEALTHCARE	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-1

Date/Time Prepared:
4/22/2021 3:02 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	82,411	9		1.00
2.00	33,831	9		2.00
3.00	-468,850	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	-1,195	0		3.07
3.08	0	0		3.08
3.09	225,929	0		3.09
3.10	-111,663	0		3.10
3.11	513,159	0		3.11
4.00	196	0		4.00
4.01	-3,379	0		4.01
4.02	1,391	0		4.02
4.03	-2,184	0		4.03
4.04	-3,510	0		4.04
4.05	-410	0		4.05
4.06	0	0		4.06
5.00	265,726			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-2

Date/Time Prepared:
4/22/2021 3:02 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER A&G	75,592	0	75,592	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	152,326	152,326	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	504,368	504,368	0	0	0	3.00
4.00	60.00	LABORATORY	16,620	791	15,829	0	0	4.00
5.00	91.00	EMERGENCY	2,081,860	1,220,595	861,265	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			2,830,766	1,878,080	952,686		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.05	OTHER A&G	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	5.05	OTHER A&G	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	152,326		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	504,368		3.00
4.00	60.00	LABORATORY	0	0	0	791		4.00
5.00	91.00	EMERGENCY	0	0	0	1,220,595		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,878,080		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/22/2021 3:02 pm	
				Respiratory Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					11	1.00
2.00	Line 1 multiplied by 15 hours per week					165	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					38	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	438.85	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.52	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.26	33.26	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					29,192	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					29,192	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					29,192	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					29,192	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					1,264	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,264	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,264	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,264	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/22/2021 3:02 pm		
				Respiratory Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.52	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						29,192	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						1,264	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						30,456	63.00
64.00	Total cost of outside supplier services (from your records)						28,596	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,264	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						1,264	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	428,477	428,477			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	256	0	256		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,197,819			1,197,819	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,896,409	604	0	1,690	2,898,703
5.01	01140	BUSINESS OFFICE	21,971	5,701	0	15,938	0
5.02	00550	DATA PROCESSING	1,163,913	6,657	0	18,610	0
5.03	00570	ADMITTING	0	3,515	0	9,826	0
5.04	00560	PURCHASING RECEIVING AND STORES	679,799	1,560	0	4,362	25,469
5.05	00590	OTHER A&G	3,332,457	83,446	0	233,277	231,817
7.00	00700	OPERATION OF PLANT	1,149,098	19,217	0	53,721	78,775
8.00	00800	LAUNDRY & LINEN SERVICE	53,284	2,032	0	5,680	0
9.00	00900	HOUSEKEEPING	439,281	4,690	0	13,110	102,438
10.00	01000	DIETARY	108,693	11,664	0	32,606	20,094
11.00	01100	CAFETERIA	199,804	4,604	0	12,870	50,099
13.00	01300	NURSING ADMINISTRATION	348,802	1,522	0	4,254	33,018
16.00	01600	MEDICAL RECORDS & LIBRARY	67,021	3,802	0	10,629	19,881
17.00	01700	SOCIAL SERVICE	136,520	1,282	0	3,583	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,690,938	65,486	0	183,068	420,763
31.00	03100	INTENSIVE CARE UNIT	25,345	9,919	0	27,729	2,043
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	577,105	18,737	0	52,379	93,328
51.00	05100	RECOVERY ROOM	228,938	21,021	0	58,766	55,657
53.00	05300	ANESTHESIOLOGY	32,335	553	0	1,546	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	992,588	16,392	0	45,824	134,039
56.00	05600	RADIOISOTOPE	141,543	2,945	0	8,232	1,255
57.00	05700	CT SCAN	187,938	1,985	0	5,548	40,944
58.00	05800	MRI	78,059	4,445	0	12,427	19,204
60.00	06000	LABORATORY	1,220,191	8,136	0	22,744	163,144
64.00	06400	INTRAVENOUS THERAPY	316,599	19,255	0	53,829	77,632
65.00	06500	RESPIRATORY THERAPY	505,657	9,280	0	25,944	111,999
66.00	06600	PHYSICAL THERAPY	554,075	8,976	0	25,093	137,943
67.00	06700	OCCUPATIONAL THERAPY	87,909	1,170	0	3,271	21,967
68.00	06800	SPEECH PATHOLOGY	31,125	433	0	1,210	9,463
69.00	06900	ELECTROCARDIOLOGY	125,193	437	0	1,222	30,572
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,859	11,990	0	33,517	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,603,866	3,391	0	9,479	56,418
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	03020	CANCER CARE CENTER	53,074	934	0	2,612	14,224
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,228,153	35,969	0	100,551	673,533
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,022,550	21,210	0	59,293	271,503
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,048,644	412,960	0	1,154,440	2,897,222
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,538	1,037	0	2,900	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,528	13,974	256	39,065	1,481
194.00	07950	OTHER NRCC	0	0	0	0	0
194.01	07951	MARKETING	0	253	0	707	0
194.02	07952	FOUNDATION	105,545	253	0	707	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	26,199,255	428,477	256	1,197,819	2,898,703

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:

From 10/01/2019

To 09/30/2020

Worksheet B

Part I

Date/Time Prepared:

4/22/2021 3:02 pm

Cost Center Description			Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	
			4A	5.01	5.02	5A.02	5.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	43,610	43,610				5.01
5.02	00550	DATA PROCESSING	1,189,180	1,994	1,191,174			5.02
5.03	00570	ADMITTING	13,341	22	0	13,363	13,363	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	711,190	1,193	0	712,383	436	5.04
5.05	00590	OTHER A&G	3,880,997	6,508	522,992	4,410,497	2,696	5.05
7.00	00700	OPERATION OF PLANT	1,300,811	2,181	530	1,303,522	798	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,996	102	0	61,098	37	8.00
9.00	00900	HOUSEKEEPING	559,519	938	0	560,457	343	9.00
10.00	01000	DIETARY	173,057	290	530	173,877	106	10.00
11.00	01100	CAFETERIA	267,377	448	0	267,825	164	11.00
13.00	01300	NURSING ADMINISTRATION	387,596	650	0	388,246	238	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,333	170	9,008	110,511	68	16.00
17.00	01700	SOCIAL SERVICE	141,385	237	0	141,622	87	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,360,255	3,958	48,219	2,412,432	1,476	30.00
31.00	03100	INTENSIVE CARE UNIT	65,036	109	530	65,675	40	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	741,549	1,244	11,657	754,450	462	50.00
51.00	05100	RECOVERY ROOM	364,382	611	3,709	368,702	226	51.00
53.00	05300	ANESTHESIOLOGY	34,434	58	1,060	35,552	22	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,188,843	1,994	82,132	1,272,969	779	54.00
56.00	05600	RADIOISOTOPE	153,975	258	0	154,233	94	56.00
57.00	05700	CT SCAN	236,415	396	0	236,811	145	57.00
58.00	05800	MRI	114,135	191	0	114,326	70	58.00
60.00	06000	LABORATORY	1,414,215	2,372	15,896	1,432,483	877	60.00
64.00	06400	INTRAVENOUS THERAPY	467,315	784	82,662	550,761	337	64.00
65.00	06500	RESPIRATORY THERAPY	652,880	1,095	83,191	737,166	451	65.00
66.00	06600	PHYSICAL THERAPY	726,087	1,218	9,008	736,313	451	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,317	192	0	114,509	70	67.00
68.00	06800	SPEECH PATHOLOGY	42,231	71	51,399	93,701	57	68.00
69.00	06900	ELECTROCARDIOLOGY	157,424	264	530	158,218	97	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	167,366	281	0	167,647	103	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,673,154	2,806	90,610	1,766,570	1,081	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	70,844	119	0	70,963	43	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,038,206	6,773	91,140	4,136,119	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,374,556	3,982	86,371	2,464,909	1,509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,988,011	43,509	1,191,174	25,987,910	13,363	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,475	0	0	43,475	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,304	101	0	60,405	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	960	0	0	960	0	194.01
194.02	07952	FOUNDATION	106,505	0	0	106,505	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,199,255	43,610	1,191,174	26,199,255	13,363	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			PURCHASING RECEIVING AND STORES	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.05	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES	712,819					5.04
5.05	00590	OTHER A&G	30,703	4,443,896	4,443,896			5.05
7.00	00700	OPERATION OF PLANT	28,165	1,332,485	272,183	1,604,668		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,135	12,488	10,593	84,216	8.00
9.00	00900	HOUSEKEEPING	39,045	599,845	122,529	24,450	0	9.00
10.00	01000	DIETARY	3,113	177,096	36,175	60,812	0	10.00
11.00	01100	CAFETERIA	7,761	275,750	56,327	24,003	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	388,484	79,354	7,934	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	374	110,953	22,664	19,824	0	16.00
17.00	01700	SOCIAL SERVICE	0	141,709	28,946	6,682	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	66,065	2,479,973	506,577	341,427	27,908	30.00
31.00	03100	INTENSIVE CARE UNIT	11,283	76,998	15,728	51,716	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	182,507	937,419	191,484	97,688	8,651	50.00
51.00	05100	RECOVERY ROOM	17,544	386,472	78,943	109,600	4,207	51.00
53.00	05300	ANESTHESIOLOGY	22,393	57,967	11,841	2,883	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,444	1,278,192	261,092	85,463	3,246	54.00
56.00	05600	RADIOISOTOPE	1,608	155,935	31,852	15,354	608	56.00
57.00	05700	CT SCAN	33,950	270,906	55,337	10,348	6,202	57.00
58.00	05800	MRI	7,821	122,217	24,965	23,176	1,483	58.00
60.00	06000	LABORATORY	36,989	1,470,349	300,344	42,419	0	60.00
64.00	06400	INTRAVENOUS THERAPY	15,403	566,501	115,717	100,392	0	64.00
65.00	06500	RESPIRATORY THERAPY	43,097	780,714	159,474	48,386	1,009	65.00
66.00	06600	PHYSICAL THERAPY	6,780	743,544	151,882	46,799	5,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	464	115,043	23,499	6,101	681	67.00
68.00	06800	SPEECH PATHOLOGY	0	93,758	19,152	2,257	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,384	165,699	33,847	2,280	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	167,750	34,266	62,511	16	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,860	1,785,511	364,721	17,678	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	165	71,171	14,538	4,872	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	16,467	4,152,586	848,231	187,532	1,153	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	73,724	2,540,142	518,867	110,584	23,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	675,109	25,950,200	4,393,023	1,523,764	84,180	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,942	77,417	15,814	5,408	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,768	64,173	13,108	72,858	36	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	960	196	1,319	0	194.01
194.02	07952	FOUNDATION	0	106,505	21,755	1,319	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	712,819	26,199,255	4,443,896	1,604,668	84,216	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	746,824					9.00
10.00	01000	DIETARY	15,031	289,114				10.00
11.00	01100	CAFETERIA	6,012	0	362,092			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,530	481,302		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,503	0	10,825	0	165,769	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	180,801	263,020	73,269	166,711	37,125	30.00
31.00	03100	INTENSIVE CARE UNIT	15,675	1,055	287	682	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,743	0	16,302	37,099	0	50.00
51.00	05100	RECOVERY ROOM	54,541	11,250	9,520	21,666	24,175	51.00
53.00	05300	ANESTHESIOLOGY	0	0	5,686	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,577	1,094	29,135	66,279	6,044	54.00
56.00	05600	RADIOISOTOPE	6,657	0	26	80	1,295	56.00
57.00	05700	CT SCAN	4,509	0	2,139	4,869	11,656	57.00
58.00	05800	MRI	10,092	0	913	2,083	2,590	58.00
60.00	06000	LABORATORY	39,510	0	32,031	72,906	18,131	60.00
64.00	06400	INTRAVENOUS THERAPY	33,927	0	15,468	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,743	0	18,911	0	0	65.00
66.00	06600	PHYSICAL THERAPY	32,424	0	12,025	0	21,153	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,295	0	2,008	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,043	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	273	5,608	12,754	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,295	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,153	0	4,382	9,974	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	0	313	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	101,137	0	78,668	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	91,904	12,422	37,873	86,199	43,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	707,529	289,114	361,962	481,302	165,769	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,295	0	130	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	746,824	289,114	362,092	481,302	165,769	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	177,337				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	177,337	4,254,148	0	4,254,148	30.00
31.00	03100	INTENSIVE CARE UNIT	0	162,141	0	162,141	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,337,386	0	1,337,386	50.00
51.00	05100	RECOVERY ROOM	0	700,374	0	700,374	51.00
53.00	05300	ANESTHESIOLOGY	0	78,377	0	78,377	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,768,122	0	1,768,122	54.00
56.00	05600	RADIOISOTOPE	0	211,807	0	211,807	56.00
57.00	05700	CT SCAN	0	365,966	0	365,966	57.00
58.00	05800	MRI	0	187,519	0	187,519	58.00
60.00	06000	LABORATORY	0	1,975,690	0	1,975,690	60.00
64.00	06400	INTRAVENOUS THERAPY	0	832,005	0	832,005	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,022,237	0	1,022,237	65.00
66.00	06600	PHYSICAL THERAPY	0	1,013,147	0	1,013,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	151,627	0	151,627	67.00
68.00	06800	SPEECH PATHOLOGY	0	116,210	0	116,210	68.00
69.00	06900	ELECTROCARDIOLOGY	0	220,461	0	220,461	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	268,838	0	268,838	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,187,419	0	2,187,419	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	90,894	0	90,894	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,369,307	0	5,369,307	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,465,287	0	3,465,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	177,337	25,778,962	0	25,778,962	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	98,639	0	98,639	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	189,600	0	189,600	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,475	0	2,475	194.01
194.02	07952	FOUNDATION	0	129,579	0	129,579	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	177,337	26,199,255	0	26,199,255	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			CAPITAL RELATED COSTS			Subtotal	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP	
			0	1.00	1.01	2.00	2A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	604	0	1,690	2,294 4.00
5.01	01140	BUSINESS OFFICE	0	5,701	0	15,938	21,639 5.01
5.02	00550	DATA PROCESSING	0	6,657	0	18,610	25,267 5.02
5.03	00570	ADMITTING	2,600	3,515	0	9,826	15,941 5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	1,560	0	4,362	5,922 5.04
5.05	00590	OTHER A&G	0	83,446	0	233,277	316,723 5.05
7.00	00700	OPERATION OF PLANT	0	19,217	0	53,721	72,938 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,032	0	5,680	7,712 8.00
9.00	00900	HOUSEKEEPING	0	4,690	0	13,110	17,800 9.00
10.00	01000	DIETARY	0	11,664	0	32,606	44,270 10.00
11.00	01100	CAFETERIA	0	4,604	0	12,870	17,474 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,522	0	4,254	5,776 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,802	0	10,629	14,431 16.00
17.00	01700	SOCIAL SERVICE	0	1,282	0	3,583	4,865 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	65,486	0	183,068	248,554 30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,919	0	27,729	37,648 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	18,737	0	52,379	71,116 50.00
51.00	05100	RECOVERY ROOM	0	21,021	0	58,766	79,787 51.00
53.00	05300	ANESTHESIOLOGY	0	553	0	1,546	2,099 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,392	0	45,824	62,216 54.00
56.00	05600	RADIOISOTOPE	0	2,945	0	8,232	11,177 56.00
57.00	05700	CT SCAN	0	1,985	0	5,548	7,533 57.00
58.00	05800	MRI	0	4,445	0	12,427	16,872 58.00
60.00	06000	LABORATORY	0	8,136	0	22,744	30,880 60.00
64.00	06400	INTRAVENOUS THERAPY	0	19,255	0	53,829	73,084 64.00
65.00	06500	RESPIRATORY THERAPY	0	9,280	0	25,944	35,224 65.00
66.00	06600	PHYSICAL THERAPY	0	8,976	0	25,093	34,069 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,170	0	3,271	4,441 67.00
68.00	06800	SPEECH PATHOLOGY	0	433	0	1,210	1,643 68.00
69.00	06900	ELECTROCARDIOLOGY	0	437	0	1,222	1,659 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,990	0	33,517	45,507 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,391	0	9,479	12,870 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00	03020	CANCER CARE CENTER	0	934	0	2,612	3,546 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	35,969	0	100,551	136,520 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	21,210	0	59,293	80,503 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,600	412,960	0	1,154,440	1,570,000 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,037	0	2,900	3,937 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,974	256	39,065	53,295 192.00
194.00	07950	OTHER NRCC	0	0	0	0	0 194.00
194.01	07951	MARKETING	0	253	0	707	960 194.01
194.02	07952	FOUNDATION	0	253	0	707	960 194.02
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers					0 201.00
202.00		TOTAL (sum lines 118 through 201)	2,600	428,477	256	1,197,819	1,629,152 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMITTING	PURCHASING RECEIVING AND STORES	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,294					4.00
5.01	01140	BUSINESS OFFICE	0	21,639				5.01
5.02	00550	DATA PROCESSING	0	989	26,256			5.02
5.03	00570	ADMITTING	0	11	0	15,952		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	20	592	0	520	7,054	5.04
5.05	00590	OTHER A&G	184	3,229	11,526	3,229	304	5.05
7.00	00700	OPERATION OF PLANT	62	1,082	12	952	279	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51	0	45	0	8.00
9.00	00900	HOUSEKEEPING	81	466	0	409	386	9.00
10.00	01000	DIETARY	16	144	12	127	31	10.00
11.00	01100	CAFETERIA	40	222	0	196	77	11.00
13.00	01300	NURSING ADMINISTRATION	26	322	0	283	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16	84	199	81	4	16.00
17.00	01700	SOCIAL SERVICE	0	118	0	103	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	333	1,964	1,063	1,761	654	30.00
31.00	03100	INTENSIVE CARE UNIT	2	54	12	48	112	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	74	617	257	551	1,804	50.00
51.00	05100	RECOVERY ROOM	44	303	82	269	174	51.00
53.00	05300	ANESTHESIOLOGY	0	29	23	26	222	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	106	989	1,810	929	44	54.00
56.00	05600	RADIOISOTOPE	1	128	0	113	16	56.00
57.00	05700	CT SCAN	32	197	0	173	336	57.00
58.00	05800	MRI	15	95	0	83	77	58.00
60.00	06000	LABORATORY	129	1,177	350	1,046	366	60.00
64.00	06400	INTRAVENOUS THERAPY	61	389	1,822	402	152	64.00
65.00	06500	RESPIRATORY THERAPY	89	543	1,834	538	426	65.00
66.00	06600	PHYSICAL THERAPY	109	604	199	538	67	66.00
67.00	06700	OCCUPATIONAL THERAPY	17	95	0	84	5	67.00
68.00	06800	SPEECH PATHOLOGY	7	35	1,133	68	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24	131	12	115	73	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	139	0	122	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45	1,392	1,997	1,290	177	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	11	59	0	52	2	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	534	3,363	2,009	0	163	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	215	1,976	1,904	1,799	730	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,293	21,589	26,256	15,952	6,681	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	336	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	50	0	0	37	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,294	21,639	26,256	15,952	7,054	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.05	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	335,195					5.05
7.00	00700	OPERATION OF PLANT	20,530	95,855				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	942	633	9,383			8.00
9.00	00900	HOUSEKEEPING	9,242	1,461	0	29,845		9.00
10.00	01000	DIETARY	2,729	3,633	0	601	51,563	10.00
11.00	01100	CAFETERIA	4,248	1,434	0	240	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,985	474	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,709	1,184	0	60	0	16.00
17.00	01700	SOCIAL SERVICE	2,183	399	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,209	20,396	3,109	7,224	46,908	30.00
31.00	03100	INTENSIVE CARE UNIT	1,186	3,089	0	626	188	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,443	5,835	964	1,948	0	50.00
51.00	05100	RECOVERY ROOM	5,954	6,547	469	2,180	2,007	51.00
53.00	05300	ANESTHESIOLOGY	893	172	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,693	5,105	362	1,502	195	54.00
56.00	05600	RADIOISOTOPE	2,402	917	68	266	0	56.00
57.00	05700	CT SCAN	4,174	618	691	180	0	57.00
58.00	05800	MRI	1,883	1,384	165	403	0	58.00
60.00	06000	LABORATORY	22,654	2,534	0	1,579	0	60.00
64.00	06400	INTRAVENOUS THERAPY	8,728	5,997	0	1,356	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,028	2,890	112	549	0	65.00
66.00	06600	PHYSICAL THERAPY	11,456	2,796	593	1,296	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,772	364	76	172	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,445	135	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,553	136	0	0	49	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,585	3,734	2	172	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,509	1,056	0	206	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	1,097	291	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	63,989	11,202	128	4,042	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	39,136	6,606	2,640	3,673	2,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	331,357	91,022	9,379	28,275	51,563	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,193	323	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	989	4,352	4	1,570	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	15	79	0	0	0	194.01
194.02	07952	FOUNDATION	1,641	79	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	335,195	95,855	9,383	29,845	51,563	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	23,931					11.00
13.00	01300	NURSING ADMINISTRATION	365	13,231				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	715	0	18,483			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	7,668		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,842	4,582	4,139	7,668	391,406	30.00
31.00	03100	INTENSIVE CARE UNIT	19	19	0	0	43,003	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,077	1,020	0	0	99,706	50.00
51.00	05100	RECOVERY ROOM	629	596	2,695	0	101,736	51.00
53.00	05300	ANESTHESIOLOGY	376	0	0	0	3,840	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,926	1,822	674	0	97,373	54.00
56.00	05600	RADIOISOTOPE	2	2	144	0	15,236	56.00
57.00	05700	CT SCAN	141	134	1,300	0	15,509	57.00
58.00	05800	MRI	60	57	289	0	21,383	58.00
60.00	06000	LABORATORY	2,117	2,004	2,022	0	66,858	60.00
64.00	06400	INTRAVENOUS THERAPY	1,022	0	0	0	93,013	64.00
65.00	06500	RESPIRATORY THERAPY	1,250	0	0	0	55,483	65.00
66.00	06600	PHYSICAL THERAPY	795	0	2,359	0	54,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	133	0	0	0	7,159	67.00
68.00	06800	SPEECH PATHOLOGY	69	0	0	0	4,535	68.00
69.00	06900	ELECTROCARDIOLOGY	371	351	0	0	5,474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	52,261	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	290	274	0	0	47,106	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	21	0	0	0	5,079	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,199	0	0	0	227,149	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,503	2,370	4,861	0	151,132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,922	13,231	18,483	7,668	1,559,322	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	5,789	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9	0	0	0	60,307	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	1,054	194.01
194.02	07952	FOUNDATION	0	0	0	0	2,680	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,931	13,231	18,483	7,668	1,629,152	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01140	BUSINESS OFFICE			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00570	ADMITTING			5.03
5.04	00560	PURCHASING RECEIVING AND STORES			5.04
5.05	00590	OTHER A&G			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	391,406	30.00
31.00	03100	INTENSIVE CARE UNIT	0	43,003	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	99,706	50.00
51.00	05100	RECOVERY ROOM	0	101,736	51.00
53.00	05300	ANESTHESIOLOGY	0	3,840	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,373	54.00
56.00	05600	RADIOISOTOPE	0	15,236	56.00
57.00	05700	CT SCAN	0	15,509	57.00
58.00	05800	MRI	0	21,383	58.00
60.00	06000	LABORATORY	0	66,858	60.00
64.00	06400	INTRAVENOUS THERAPY	0	93,013	64.00
65.00	06500	RESPIRATORY THERAPY	0	55,483	65.00
66.00	06600	PHYSICAL THERAPY	0	54,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,159	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,535	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,474	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	52,261	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,106	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	5,079	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	227,149	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	151,132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,559,322	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,789	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	60,307	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	1,054	194.01
194.02	07952	FOUNDATION	0	2,680	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,629,152	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
			1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,958					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			99,958			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141	0	141	10,778,051		4.00
5.01	01140	BUSINESS OFFICE	1,330	0	1,330	0	-43,610	5.01
5.02	00550	DATA PROCESSING	1,553	0	1,553	0	0	5.02
5.03	00570	ADMITTING	820	0	820	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	364	0	364	94,698	0	5.04
5.05	00590	OTHER A&G	19,467	0	19,467	861,950	0	5.05
7.00	00700	OPERATION OF PLANT	4,483	0	4,483	292,902	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	474	0	0	8.00
9.00	00900	HOUSEKEEPING	1,094	0	1,094	380,888	0	9.00
10.00	01000	DIETARY	2,721	0	2,721	74,716	0	10.00
11.00	01100	CAFETERIA	1,074	0	1,074	186,279	0	11.00
13.00	01300	NURSING ADMINISTRATION	355	0	355	122,770	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	887	73,923	0	16.00
17.00	01700	SOCIAL SERVICE	299	0	299	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,277	0	15,277	1,564,493	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,314	0	2,314	7,598	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,371	0	4,371	347,016	0	50.00
51.00	05100	RECOVERY ROOM	4,904	0	4,904	206,946	0	51.00
53.00	05300	ANESTHESIOLOGY	129	0	129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824	0	3,824	498,390	0	54.00
56.00	05600	RADIOISOTOPE	687	0	687	4,666	0	56.00
57.00	05700	CT SCAN	463	0	463	152,238	0	57.00
58.00	05800	MRI	1,037	0	1,037	71,405	0	58.00
60.00	06000	LABORATORY	1,898	0	1,898	606,607	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,492	0	4,492	288,655	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,165	0	2,165	416,439	0	65.00
66.00	06600	PHYSICAL THERAPY	2,094	0	2,094	512,904	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	273	0	273	81,678	0	67.00
68.00	06800	SPEECH PATHOLOGY	101	0	101	35,184	0	68.00
69.00	06900	ELECTROCARDIOLOGY	102	0	102	113,673	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,797	0	2,797	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	791	209,775	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	218	0	218	52,887	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,391	0	8,391	2,504,351	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,948	0	4,948	1,009,512	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,338	0	96,338	10,772,543	-43,610	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	0	242	0	-43,475	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,260	100	3,260	5,508	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	59	0	59	0	-960	194.01
194.02	07952	FOUNDATION	59	0	59	0	-106,505	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	428,477	256	1,197,819	2,898,703		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.286570	2.560000	11.983223	0.268945		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				2,294		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000213		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HO URS)	Reconciliatio n	ADMITTING (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			5.01	5.02	5A.03	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	26,004,705					5.01
5.02	00550	DATA PROCESSING	1,189,180	2,248				5.02
5.03	00570	ADMITTING	13,341	0	-13,363	21,838,428		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	711,190	0	0	712,383	806,827	5.04
5.05	00590	OTHER A&G	3,880,997	987	0	4,410,497	34,752	5.05
7.00	00700	OPERATION OF PLANT	1,300,811	1	0	1,303,522	31,879	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,996	0	0	61,098	0	8.00
9.00	00900	HOUSEKEEPING	559,519	0	0	560,457	44,194	9.00
10.00	01000	DIETARY	173,057	1	0	173,877	3,523	10.00
11.00	01100	CAFETERIA	267,377	0	0	267,825	8,785	11.00
13.00	01300	NURSING ADMINISTRATION	387,596	0	0	388,246	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,333	17	0	110,511	423	16.00
17.00	01700	SOCIAL SERVICE	141,385	0	0	141,622	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,360,255	91	0	2,412,432	74,778	30.00
31.00	03100	INTENSIVE CARE UNIT	65,036	1	0	65,675	12,771	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	741,549	22	0	754,450	206,579	50.00
51.00	05100	RECOVERY ROOM	364,382	7	0	368,702	19,858	51.00
53.00	05300	ANESTHESIOLOGY	34,434	2	0	35,552	25,346	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,188,843	155	0	1,272,969	5,030	54.00
56.00	05600	RADIOISOTOPE	153,975	0	0	154,233	1,820	56.00
57.00	05700	CT SCAN	236,415	0	0	236,811	38,427	57.00
58.00	05800	MRI	114,135	0	0	114,326	8,852	58.00
60.00	06000	LABORATORY	1,414,215	30	0	1,432,483	41,867	60.00
64.00	06400	INTRAVENOUS THERAPY	467,315	156	0	550,761	17,434	64.00
65.00	06500	RESPIRATORY THERAPY	652,880	157	0	737,166	48,781	65.00
66.00	06600	PHYSICAL THERAPY	726,087	17	0	736,313	7,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,317	0	0	114,509	525	67.00
68.00	06800	SPEECH PATHOLOGY	42,231	97	0	93,701	0	68.00
69.00	06900	ELECTROCARDIOLOGY	157,424	1	0	158,218	8,358	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	167,366	0	0	167,647	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,673,154	171	0	1,766,570	20,215	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	70,844	0	0	70,963	187	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,038,206	172	-4,136,119	0	18,639	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,374,556	163	0	2,464,909	83,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,944,401	2,248	-4,149,482	21,838,428	764,144	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-43,475	0	38,418	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,304	0	-60,405	0	4,265	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	-960	0	0	194.01
194.02	07952	FOUNDATION	0	0	-106,505	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	43,610	1,191,174		13,363	712,819	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001677	529.881673		0.000612	0.883484	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,639	26,256		15,952	7,054	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000832	11.679715		0.000730	0.008743	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description		Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A.05	5.05	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G	-4,443,896	21,755,359			5.05
7.00	00700	OPERATION OF PLANT	0	1,332,485	71,800		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,135	474	79,478	8.00
9.00	00900	HOUSEKEEPING	0	599,845	1,094	0	9.00
10.00	01000	DIETARY	0	177,096	2,721	0	10.00
11.00	01100	CAFETERIA	0	275,750	1,074	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	388,484	355	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	110,953	887	0	16.00
17.00	01700	SOCIAL SERVICE	0	141,709	299	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,479,973	15,277	26,338	30.00
31.00	03100	INTENSIVE CARE UNIT	0	76,998	2,314	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	937,419	4,371	8,164	50.00
51.00	05100	RECOVERY ROOM	0	386,472	4,904	3,970	51.00
53.00	05300	ANESTHESIOLOGY	0	57,967	129	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,278,192	3,824	3,063	54.00
56.00	05600	RADIOISOTOPE	0	155,935	687	574	56.00
57.00	05700	CT SCAN	0	270,906	463	5,853	57.00
58.00	05800	MRI	0	122,217	1,037	1,400	58.00
60.00	06000	LABORATORY	0	1,470,349	1,898	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	566,501	4,492	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	780,714	2,165	952	65.00
66.00	06600	PHYSICAL THERAPY	0	743,544	2,094	5,021	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	115,043	273	643	67.00
68.00	06800	SPEECH PATHOLOGY	0	93,758	101	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	165,699	102	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	167,750	2,797	15	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,785,511	791	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	71,171	218	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,152,586	8,391	1,088	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,540,142	4,948	22,363	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,443,896	21,506,304	68,180	79,444	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	77,417	242	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	64,173	3,260	34	192.00
194.00	07950	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MARKETING	0	960	59	0	194.01
194.02	07952	FOUNDATION	0	106,505	59	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		4,443,896	1,604,668	84,216	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.204267	22.349136	1.059614	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		335,195	95,855	9,383	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.015407	1.335028	0.118058	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	7,401					10.00
11.00	01100	CAFETERIA	0	13,882				11.00
13.00	01300	NURSING ADMINISTRATION	0	212	168,654			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	415	0	384		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	308	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,733	2,809	58,418	86	308	30.00
31.00	03100	INTENSIVE CARE UNIT	27	11	239	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	625	13,000	0	0	50.00
51.00	05100	RECOVERY ROOM	288	365	7,592	56	0	51.00
53.00	05300	ANESTHESIOLOGY	0	218	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28	1,117	23,225	14	0	54.00
56.00	05600	RADIOISOTOPE	0	1	28	3	0	56.00
57.00	05700	CT SCAN	0	82	1,706	27	0	57.00
58.00	05800	MRI	0	35	730	6	0	58.00
60.00	06000	LABORATORY	0	1,228	25,547	42	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	593	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	725	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	461	0	49	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	77	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	40	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7	215	4,469	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	168	3,495	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	12	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,016	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	318	1,452	30,205	101	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,401	13,877	168,654	384	308	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	5	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	289,114	362,092	481,302	165,769	177,337	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.064181	26.083561	2.853783	431.690104	575.769481	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,563	23,931	13,231	18,483	7,668	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.967031	1.723887	0.078451	48.132813	24.896104	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 3:02 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,254,148		4,254,148	0
31.00	03100	INTENSIVE CARE UNIT	162,141		162,141	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,337,386		1,337,386	0
51.00	05100	RECOVERY ROOM	700,374		700,374	0
53.00	05300	ANESTHESIOLOGY	78,377		78,377	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,768,122		1,768,122	0
56.00	05600	RADIOISOTOPE	211,807		211,807	0
57.00	05700	CT SCAN	365,966		365,966	0
58.00	05800	MRI	187,519		187,519	0
60.00	06000	LABORATORY	1,975,690		1,975,690	0
64.00	06400	INTRAVENOUS THERAPY	832,005		832,005	0
65.00	06500	RESPIRATORY THERAPY	1,022,237	0	1,022,237	0
66.00	06600	PHYSICAL THERAPY	1,013,147	0	1,013,147	0
67.00	06700	OCCUPATIONAL THERAPY	151,627	0	151,627	0
68.00	06800	SPEECH PATHOLOGY	116,210	0	116,210	0
69.00	06900	ELECTROCARDIOLOGY	220,461		220,461	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	268,838		268,838	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,187,419		2,187,419	0
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0
76.00	03020	CANCER CARE CENTER	90,894		90,894	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,369,307		5,369,307	0
90.00	09000	CLINIC	0		0	0
91.00	09100	EMERGENCY	3,465,287		3,465,287	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	635,340		635,340	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	26,414,302	0	26,414,302	0
201.00		Less Observation Beds	635,340		635,340	0
202.00		Total (see instructions)	25,778,962	0	25,778,962	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 3:02 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	3,197,460		3,197,460		30.00
31.00	03100	INTENSIVE CARE UNIT	31,004		31,004		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	284,909	4,079,876	4,364,785	0.306404	0.000000
51.00	05100	RECOVERY ROOM	11,257	886,639	897,896	0.780017	0.000000
53.00	05300	ANESTHESIOLOGY	158,956	1,821,646	1,980,602	0.039572	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,727	4,901,284	5,134,011	0.344394	0.000000
56.00	05600	RADIOISOTOPE	25,432	930,439	955,871	0.221585	0.000000
57.00	05700	CT SCAN	536,955	8,408,149	8,945,104	0.040912	0.000000
58.00	05800	MRI	90,776	2,217,500	2,308,276	0.081238	0.000000
60.00	06000	LABORATORY	1,095,530	11,656,580	12,752,110	0.154930	0.000000
64.00	06400	INTRAVENOUS THERAPY	328	947,861	948,189	0.877467	0.000000
65.00	06500	RESPIRATORY THERAPY	743,815	539,453	1,283,268	0.796589	0.000000
66.00	06600	PHYSICAL THERAPY	276,639	2,845,634	3,122,273	0.324490	0.000000
67.00	06700	OCCUPATIONAL THERAPY	44,920	352,165	397,085	0.381850	0.000000
68.00	06800	SPEECH PATHOLOGY	9,761	135,395	145,156	0.800587	0.000000
69.00	06900	ELECTROCARDIOLOGY	183,481	2,924,542	3,108,023	0.070933	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,102	778,485	812,587	0.330842	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,531,266	6,211,714	7,742,980	0.282504	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
76.00	03020	CANCER CARE CENTER	326	106,563	106,889	0.850359	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,756,582	5,756,582		88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	160,204	4,920,055	5,080,259	0.682108	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	43,107	516,172	559,279	1.135998	0.000000
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	8,692,955	60,936,734	69,629,689		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,692,955	60,936,734	69,629,689		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03020	CANCER CARE CENTER	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	99,706	4,364,785	0.022843	136,320	3,114
51.00	05100	RECOVERY ROOM	101,736	897,896	0.113305	3,602	408
53.00	05300	ANESTHESIOLOGY	3,840	1,980,602	0.001939	77,520	150
54.00	05400	RADIOLOGY-DIAGNOSTIC	97,373	5,134,011	0.018966	115,949	2,199
56.00	05600	RADIOISOTOPE	15,236	955,871	0.015939	18,922	302
57.00	05700	CT SCAN	15,509	8,945,104	0.001734	131,148	227
58.00	05800	MRI	21,383	2,308,276	0.009264	19,166	178
60.00	06000	LABORATORY	66,858	12,752,110	0.005243	420,275	2,204
64.00	06400	INTRAVENOUS THERAPY	93,013	948,189	0.098095	0	0
65.00	06500	RESPIRATORY THERAPY	55,483	1,283,268	0.043236	330,622	14,295
66.00	06600	PHYSICAL THERAPY	54,881	3,122,273	0.017577	28,346	498
67.00	06700	OCCUPATIONAL THERAPY	7,159	397,085	0.018029	4,052	73
68.00	06800	SPEECH PATHOLOGY	4,535	145,156	0.031242	878	27
69.00	06900	ELECTROCARDIOLOGY	5,474	3,108,023	0.001761	108,412	191
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,261	812,587	0.064314	16,068	1,033
73.00	07300	DRUGS CHARGED TO PATIENTS	47,106	7,742,980	0.006084	564,661	3,435
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0
76.00	03020	CANCER CARE CENTER	5,079	106,889	0.047517	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	227,149	5,756,582	0.039459	0	0
90.00	09000	CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	151,132	5,080,259	0.029749	24,127	718
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	58,455	559,279	0.104518	1,125	118
200.00		Total (lines 50 through 199)	1,183,368	66,401,225		2,001,193	29,170

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 3:02 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 3:02 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,364,785	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	897,896	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,980,602	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,134,011	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	955,871	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	8,945,104	0.000000	57.00
58.00	05800	MRI	0	0	0	2,308,276	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	12,752,110	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	948,189	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,283,268	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,122,273	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	397,085	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	145,156	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,108,023	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	812,587	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,742,980	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03020	CANCER CARE CENTER	0	0	0	106,889	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,756,582	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,080,259	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	559,279	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	66,401,225		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 3:02 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	136,320	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	3,602	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	77,520	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	115,949	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	18,922	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	131,148	0	0	0	57.00
58.00	05800	MRI	0.000000	19,166	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	420,275	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	330,622	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	28,346	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,052	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	878	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	108,412	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	16,068	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	564,661	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	24,127	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,125	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,001,193	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/22/2021 3:02 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.306404	0	1,511,639	0	0	50.00
51.00	05100	RECOVERY ROOM	0.780017	0	319,971	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.039572	0	578,989	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.344394	0	1,641,414	0	0	54.00
56.00	05600	RADIOISOTOPE	0.221585	0	456,712	0	0	56.00
57.00	05700	CT SCAN	0.040912	0	3,712,381	0	0	57.00
58.00	05800	MRI	0.081238	0	826,345	0	0	58.00
60.00	06000	LABORATORY	0.154930	0	4,566,916	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.877467	0	528,390	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.796589	0	281,876	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.324490	0	1,102,533	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381850	0	60,639	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.800587	0	21,074	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070933	0	1,353,356	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.330842	0	222,256	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282504	0	3,352,699	9,362	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0.850359	0	52,234	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.682108	0	1,792,144	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.135998	0	280,753	0	0	92.00
200.00		Subtotal (see instructions)		0	22,662,321	9,362	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	22,662,321	9,362	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/22/2021 3:02 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	463,172	0		50.00
51.00	05100	RECOVERY ROOM	249,583	0		51.00
53.00	05300	ANESTHESIOLOGY	22,912	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,293	0		54.00
56.00	05600	RADIOISOTOPE	101,201	0		56.00
57.00	05700	CT SCAN	151,881	0		57.00
58.00	05800	MRI	67,131	0		58.00
60.00	06000	LABORATORY	707,552	0		60.00
64.00	06400	INTRAVENOUS THERAPY	463,645	0		64.00
65.00	06500	RESPIRATORY THERAPY	224,539	0		65.00
66.00	06600	PHYSICAL THERAPY	357,761	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,155	0		67.00
68.00	06800	SPEECH PATHOLOGY	16,872	0		68.00
69.00	06900	ELECTROCARDIOLOGY	95,998	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,532	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	947,151	2,645		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03020	CANCER CARE CENTER	44,418	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,222,436	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	318,935	0		92.00
200.00		Subtotal (see instructions)	6,117,167	2,645		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,117,167	2,645		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/22/2021 3:02 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,531	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,381	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,026	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		245	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)		736	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		42	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)		127	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		708	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)		219	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)		655	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		159.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		159.14	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,254,148	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)		6,684	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)		20,211	25.00
26.00	Total swing-bed cost (see instructions)		1,782,581	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,471,567	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,471,567	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,789.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,267,101	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,267,101	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/22/2021 3:02 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	162,141	5	32,428.20	4	129,713	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)					628,886	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,025,700	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)					391,942	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,172,247	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,564,189	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)					355	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,789.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					635,340	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/22/2021 3:02 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	391,406	4,254,148	0.092006	635,340	58,455	90.00
91.00	Nursing School cost	0	4,254,148	0.000000	635,340	0	91.00
92.00	Allied health cost	0	4,254,148	0.000000	635,340	0	92.00
93.00	All other Medical Education	0	4,254,148	0.000000	635,340	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/22/2021 3:02 pm
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		773,032	30.00
31.00	03100	INTENSIVE CARE UNIT		8,229	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306404	136,320	50.00
51.00	05100	RECOVERY ROOM	0.780017	3,602	51.00
53.00	05300	ANESTHESIOLOGY	0.039572	77,520	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.344394	115,949	54.00
56.00	05600	RADIOISOTOPE	0.221585	18,922	56.00
57.00	05700	CT SCAN	0.040912	131,148	57.00
58.00	05800	MRI	0.081238	19,166	58.00
60.00	06000	LABORATORY	0.154930	420,275	60.00
64.00	06400	INTRAVENOUS THERAPY	0.877467	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.796589	330,622	65.00
66.00	06600	PHYSICAL THERAPY	0.324490	28,346	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381850	4,052	67.00
68.00	06800	SPEECH PATHOLOGY	0.800587	878	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070933	108,412	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.330842	16,068	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282504	564,661	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03020	CANCER CARE CENTER	0.850359	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.682108	24,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.135998	1,125	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,001,193	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,001,193	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/22/2021 3:02 pm
			Component CCN: 14-Z310		
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306404	0	50.00
51.00	05100	RECOVERY ROOM	0.780017	0	51.00
53.00	05300	ANESTHESIOLOGY	0.039572	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.344394	28,450	54.00
56.00	05600	RADIOISOTOPE	0.221585	4,719	56.00
57.00	05700	CT SCAN	0.040912	56,343	57.00
58.00	05800	MRI	0.081238	19,119	58.00
60.00	06000	LABORATORY	0.154930	264,045	60.00
64.00	06400	INTRAVENOUS THERAPY	0.877467	22	64.00
65.00	06500	RESPIRATORY THERAPY	0.796589	216,278	65.00
66.00	06600	PHYSICAL THERAPY	0.324490	175,691	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.381850	30,324	67.00
68.00	06800	SPEECH PATHOLOGY	0.800587	3,482	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070933	18,426	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.330842	568	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.282504	482,063	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03020	CANCER CARE CENTER	0.850359	326	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.682108	24,982	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.135998	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,324,838	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,324,838	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/22/2021 3:02 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,119,812 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,119,812 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			6,181,010 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)			41,527 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			3,623,624 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,515,859 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,515,859 30.00
31.00	Primary payer payments			197 31.00
32.00	Subtotal (line 30 minus line 31)			2,515,662 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)			387,001 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			251,551 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			268,539 36.00
37.00	Subtotal (see instructions)			2,767,213 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)			2,767,213 40.00
40.01	Sequestration adjustment (see instructions)			32,100 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,034,938 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			-299,825 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/22/2021 3:02 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		2,000,478		3,550,417	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/09/2020	41,930	09/09/2020	515,479	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)		-41,930		-515,479	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)		1,958,548		3,034,938	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		139,004		299,825	6.02
7.00	Total Medicare program liability (see instructions)		1,819,544		2,735,113	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1310

Period:

Worksheet E-1

Component CCN: 14-Z310

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/22/2021 3:02 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		2,137,291		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/09/2020	36,615		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)		-36,615		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,100,676		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		107,375		0	6.02
7.00	Total Medicare program liability (see instructions)		1,993,301		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/22/2021 3:02 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet E-2
		Component CCN: 14-Z310		Date/Time Prepared: 4/22/2021 3:02 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)		1,579,831	0 1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		458,831	0 3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00 4.00
5.00	Program days		874	0 5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0 6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,038,662	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		2,038,662	0 10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0 11.00
12.00	Subtotal (line 10 minus line 11)		2,038,662	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		21,967	0 13.00
14.00	80% of Part B costs (line 12 x 80%)			0 14.00
15.00	Subtotal (see instructions)		2,016,695	0 15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0	16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0 16.99
17.00	Allowable bad debts (see instructions)		0	0 17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0 17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0 18.00
19.00	Total (see instructions)		2,016,695	0 19.00
19.01	Sequestration adjustment (see instructions)		23,394	0 19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0 19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments		2,100,676	0 20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)		0	0 21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-107,375	0 22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0 23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1310	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 4/22/2021 3:02 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,025,700	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,025,700	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,045,957	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,045,957	19.00
20.00	Deductibles (exclude professional component)		222,785	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,823,172	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,823,172	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		27,271	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		17,726	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		18,436	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,840,898	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)		1,840,898	30.00
30.01	Sequestration adjustment (see instructions)		21,354	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,958,548	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-139,004	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet G

Date/Time Prepared:
4/22/2021 3:02 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	1,319,748	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	12,551,835	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-7,913,251	0	0	0	6.00
7.00 Inventory	718,557	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	98	0	0	0	9.00
10.00 Due from other funds	13,696	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	6,690,683	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,927,000	0	0	0	12.00
13.00 Land improvements	2,056,749	0	0	0	13.00
14.00 Accumulated depreciation	-1,595,479	0	0	0	14.00
15.00 Buildings	16,249,923	0	0	0	15.00
16.00 Accumulated depreciation	-7,433,951	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	13,548,142	0	0	0	23.00
24.00 Accumulated depreciation	-10,688,357	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	14,064,027	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	194,574	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	12,656,299	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	12,850,873	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	33,605,583	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	395,712	0	0	0	37.00
38.00 Salaries, wages, and fees payable	0	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	456,000	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	5,933,156	0	0	0	43.00
44.00 Other current liabilities	112,320	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	6,897,188	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	18,460,538	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	18,460,538	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	25,357,726	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	8,247,857				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)	8,247,857	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	33,605,583	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-1

Date/Time Prepared:
4/22/2021 3:02 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		3,798,700		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,710,098				2.00
3.00	Total (sum of line 1 and line 2)		8,508,798		0		3.00
4.00	OPERATIONS	471		0		0	4.00
5.00	TEMP RESTRICTED FUNDS	37,823		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)		38,294		0		10.00
11.00	Subtotal (line 3 plus line 10)		8,547,092		0		11.00
12.00	EQUITY TRANSFER	299,235		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		299,235		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,247,857		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	OPERATIONS		0				4.00
5.00	TEMP RESTRICTED FUNDS		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	EQUITY TRANSFER		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/22/2021 3:02 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,134,931		2,134,931	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	906,383		906,383	5.00
6.00	Swing bed - NF	156,146		156,146	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,197,460		3,197,460	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	31,004		31,004	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)	31,004		31,004	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,228,464		3,228,464	17.00
18.00	Ancillary services	5,261,180	49,743,925	55,005,105	18.00
19.00	Outpatient services	203,311	5,436,227	5,639,538	19.00
20.00	RURAL HEALTH CLINIC	0	5,756,582	5,756,582	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	141,050	3,032,720	3,173,770	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,834,005	63,969,454	72,803,459	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,721,402		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)		30,721,402		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1310

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-3

Date/Time Prepared:
4/22/2021 3:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,803,459	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,318,495	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,484,964	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,721,402	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-236,438	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	131,813	6.00
7.00	Income from investments	4,795	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	70,272	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	1,690,402	17.00
18.00	Revenue from sale of medical records and abstracts	7,766	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	1,215	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	44,549	20.00
21.00	Rental of vending machines	913	21.00
22.00	Rental of hospital space	21,341	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	263,252	24.00
24.50	COVID-19 PHE Funding	3,238,599	24.50
25.00	Total other income (sum of lines 6-24)	5,474,917	25.00
26.00	Total (line 5 plus line 25)	5,238,479	26.00
27.00	EQUITY TRANSFER	528,381	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	528,381	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,710,098	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/22/2021 3:02 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	988,659	0	988,659	-152,032	836,627
2.00	Physician Assistant	150,950	0	150,950	-2,573	148,377
3.00	Nurse Practitioner	330,516	0	330,516	-9,492	321,024
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	880,238	0	880,238	-8,483	871,755
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	2,350,363	0	2,350,363	-172,580	2,177,783
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	227,754	227,754	0	227,754
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	11,411	11,411	0	11,411
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	239,165	239,165	0	239,165
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,350,363	239,165	2,589,528	-172,580	2,416,948
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	53,547	53,547
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	53,547	53,547
FACILITY OVERHEAD						
29.00	Facility Costs	0	68,638	68,638	-54,210	14,428
30.00	Administrative Costs	274,861	1,230,931	1,505,792	-695,562	810,230
31.00	Total Facility Overhead (sum of lines 29 and 30)	274,861	1,299,569	1,574,430	-749,772	824,658
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,625,224	1,538,734	4,163,958	-868,805	3,295,153

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/22/2021 3:02 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	836,627	1.00
2.00	Physician Assistant	0	148,377	2.00
3.00	Nurse Practitioner	0	321,024	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	871,755	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,177,783	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	227,754	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	11,411	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	239,165	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,416,948	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	53,547	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	53,547	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	14,428	29.00
30.00	Administrative Costs	-67,000	743,230	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-67,000	757,658	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-67,000	3,228,153	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1310

Period:

Worksheet M-2

Component CCN: 14-8535

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/22/2021 3:02 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	3.19	11,526	3,612	11,522	1.00
2.00	Physician Assistant	0.93	2,150	2,100	1,953	2.00
3.00	Nurse Practitioner	2.69	5,219	1,932	5,197	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.81	18,895		18,672	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.81	18,895		18,895	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,416,948	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				53,547	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,470,495	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.978325	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				757,658	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,141,154	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,898,812	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,898,812	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,835,980	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,252,928	20.00

Health Financial Systems		MENDOTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1310	Period: From 10/01/2019	Worksheet M-3	
		Component CCN:14-8535	To 09/30/2020	Date/Time Prepared: 4/22/2021 3:02 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)			5,252,928	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			268,056	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,984,872	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			18,895	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)			18,895	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			263.82	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		263.82	263.82	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,633	4,899	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		430,818	1,292,454	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	1,723,272	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,509,958	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			13,843	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			15,799	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.)			1,247,662	16.04
16.05	Total program cost (see instructions)		0	1,263,461	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			147,896	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			268,086	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,263,461	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			106,831	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,370,292	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)			1,370,292	26.00
26.01	Sequestration adjustment (see instructions)			15,895	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,222,146	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)			132,251	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/22/2021 3:02 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)		2,177,783	2,177,783	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001723	0.007472	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,752	16,272	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		68,471	34,841	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		72,223	51,113	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,416,948	2,416,948	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,835,980	2,835,980	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.029882	0.021148	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		84,745	59,975	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		156,968	111,088	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		542	2,351	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		289.61	47.25	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		224	888	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		64,873	41,958	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)			268,056	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)			106,831	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/22/2021 3:02 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		1,411,929	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		09/09/2020	189,783		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)		-189,783		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,222,146		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		132,251		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,354,397		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00