

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/28/2021 12:36 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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 BCC DBA ILLINI COMMUNITY HOSPITAL (14-1315) 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) TIMOTHY MOORE
 Officer or Administrator of Provider(s)

VP-FINANCE, CAO
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-204,124	-142,794	0	0	1.00
2.00	Subprovider - IPF	0	21,880	71		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-43,735	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		25,552		0	10.00
200.00	Total	0	-225,979	-117,171	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 12:36 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 640 WEST WASHINGTON			PO Box:				1.00		
2.00	City: PITTSFIELD			State: IL		Zip Code: 62363		County:		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	1	09/01/2001	N	O	N
4.00	Subprovider - IPF		BCC DBA ILLINI COMM HOSP GERIPSYCH	14M315	99914	4	10/01/2015	N	P	N
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		BCC DBA ILLINI COMM HOSP-SWINGBED	14Z315	99914		09/01/2001	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		BCC DBA ILLINI COMM HOSP RHC	143482	99914		07/03/2006	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2019	09/30/2020		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 12:36 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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
			0.000000			64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 12:36 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	90,110	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	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	14H132	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 12:36 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: BLESSING CORPORATE SERVICES		Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131		141.00		
142.00	Street: BROADWAY AT 11TH STREET		PO Box:				142.00		
143.00	City: QUINCY		State: IL		Zip Code: 62301		143.00		
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N	155.00	
156.00	Subprovider - IPF			N	N	N	N	156.00	
157.00	Subprovider - IRF			N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF			N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N	160.00	
161.00	CMHC				N	N	N	161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00	
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/28/2021 12:36 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/28/2021	Y 02/28/2021
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/28/2021 12:36 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CONNIE.ZIEGLER@BLESSINGHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/28/2021 12:36 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT COORDINATOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	15,744.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	15,744.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	15,744.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		35			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 12:36 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)	447	25	656			1.00
2.00	HMO and other (see instructions)	78	77				2.00
3.00	HMO IPF Subprovider	264	280				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	269	0	269			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	68			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	716	25	993			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)	716	25	993	0.00	150.79	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	788	38	1,663	0.00	16.16	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,521	0	10,382	0.00	18.27	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	185.22	27.00
28.00	Observation Bed Days		0	208			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			6			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 12:36 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	164	16	253	1.00
2.00 HMO and other (see instructions)			27	29		2.00
3.00 HMO IPF Subprovider				40		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	164	16	253	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	106	6	214	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		BCC DBA ILLINI COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1315 Component CCN: 14-3482		Period: From 10/01/2019 To 09/30/2020
			Worksheet S-8		Date/Time Prepared: 4/28/2021 12:36 pm
			RHC I		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street		640 WEST WASHINGTON		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		PITTSFIELD IL 62363		2.00
			1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)		5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		6.00		
7.00	Appalachian Regional Commission		7.00		
8.00	Look-Alikes		8.00		
9.00	OTHER (SPECIFY)		9.00		
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
			Sunday		Monday
			from	to	from
			1.00	2.00	3.00
			Tuesday		from
			1.00		2.00
11.00	Facility hours of operations (1)				
	CLINIC		07:00	17:00	07:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
			Y/N		V
			1.00		2.00
			XVIII		XIX
			3.00		4.00
			Total Visits		5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
			County		4.00
2.00	City, State, ZIP Code, County		PIKE		
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
			Thursday		from
			to		10.00
			11.00		11.00
11.00	Facility hours of operations (1)				
	CLINIC		17:00	07:00	17:00
			07:00		17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1315 Component CCN: 14-3482		Period: From 10/01/2019 To 09/30/2020		Worksheet S-8 Date/Time Prepared: 4/28/2021 12:36 pm	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	07:00	17:00	08:00	11:30				11.00

Health Financial Systems		BCC DBA ILLINI COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-10	
				Date/Time Prepared: 4/28/2021 12:36 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)			0.400955	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2,286,385	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			1,321,546	5.00
6.00	Medicaid charges			11,909,633	6.00
7.00	Medicaid cost (line 1 times line 6)			4,775,227	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)			1,167,296	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)			1,167,296	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)	460,564	752,822	1,213,386	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	184,665	752,822	937,487	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)	184,665	752,822	937,487	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)			1,889,497	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			404,477	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			622,271	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,267,226	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			725,895	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,663,382	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,830,678	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1315

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

Worksheet A

Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		757,522	757,522	51,635	809,157	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		382,822	382,822	3,065	385,887	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,697,119	3,697,119	0	3,697,119	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,816,930	2,544,325	4,361,255	-30,011	4,331,244	5.00
6.00	00600	MAINTENANCE & REPAIRS	441,980	431,800	873,780	0	873,780	6.00
7.00	00700	OPERATION OF PLANT	0	445,571	445,571	43,773	489,344	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,593	40,593	0	40,593	8.00
9.00	00900	HOUSEKEEPING	320,502	159,913	480,415	0	480,415	9.00
10.00	01000	DIETARY	218,662	146,849	365,511	0	365,511	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	245,606	3,043	248,649	-75,192	173,457	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,086	39,070	76,156	0	76,156	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	287,922	287,922	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	34,945	34,945	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	910,655	235,540	1,146,195	-76,968	1,069,227	30.00
40.00	04000	SUBPROVIDER - IPF	929,365	138,385	1,067,750	-139,813	927,937	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	459,727	103,310	563,037	-8,264	554,773	50.00
53.00	05300	ANESTHESIOLOGY	34,945	4,614	39,559	-39,559	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	997,519	367,400	1,364,919	-1,754	1,363,165	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	70,675	28,003	98,678	-20,700	77,978	54.01
60.00	06000	LABORATORY	522,239	979,866	1,502,105	-47,295	1,454,810	60.00
65.00	06500	RESPIRATORY THERAPY	31,236	39,052	70,288	-15,265	55,023	65.00
65.01	03610	SLEEP LAB	269	38,556	38,825	0	38,825	65.01
66.00	06600	PHYSICAL THERAPY	0	49,934	49,934	0	49,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,406	10,739	68,145	0	68,145	67.00
68.00	06800	SPEECH PATHOLOGY	23,500	4,315	27,815	0	27,815	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,856	143,380	210,236	108,042	318,278	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	432,710	2,730,243	3,162,953	-847	3,162,106	73.00
73.01	03480	ONCOLOGY	113,962	28,222	142,184	0	142,184	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,381,323	432,351	1,813,674	-350	1,813,324	88.00
91.00	09100	EMERGENCY	1,849,425	2,057,431	3,906,856	-6,867	3,899,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		74,307	74,307	0	74,307	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,962,578	16,114,275	27,076,853	66,497	27,143,350	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	66,949	39,004	105,953	0	105,953	192.00
192.01	19201	XPRESS CARE	454,423	46,190	500,613	0	500,613	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	124,257	73,537	197,794	-66,497	131,297	193.04
200.00		TOTAL (SUM OF LINES 118 through 199)	11,608,207	16,273,006	27,881,213	0	27,881,213	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1315

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

Worksheet A

Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	165,366	974,523	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	122,942	508,829	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-743,803	2,953,316	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,950,755	6,281,999	5.00
6.00	00600	MAINTENANCE & REPAIRS	-15,697	858,083	6.00
7.00	00700	OPERATION OF PLANT	-3,308	486,036	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-947	39,646	8.00
9.00	00900	HOUSEKEEPING	0	480,415	9.00
10.00	01000	DIETARY	-67,777	297,734	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	173,457	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	211,690	287,846	16.00
17.00	01700	SOCIAL SERVICE	0	287,922	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	34,945	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-24,935	1,044,292	30.00
40.00	04000	SUBPROVIDER - IPF	-91	927,846	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-7,852	546,921	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-50,635	1,312,530	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	77,978	54.01
60.00	06000	LABORATORY	-356,395	1,098,415	60.00
65.00	06500	RESPIRATORY THERAPY	-29	54,994	65.00
65.01	03610	SLEEP LAB	-10,474	28,351	65.01
66.00	06600	PHYSICAL THERAPY	0	49,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	68,145	67.00
68.00	06800	SPEECH PATHOLOGY	0	27,815	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,342	383,620	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,574	3,183,680	73.00
73.01	03480	ONCOLOGY	-69,930	72,254	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-72,065	1,741,259	88.00
91.00	09100	EMERGENCY	-1,267,638	2,632,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-74,307	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-228,214	26,915,136	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-58	105,895	192.00
192.01	19201	XPRESS CARE	0	500,613	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	RENAL	0	0	193.01
193.02	19302	LEASED SPACE	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	193.03
193.04	19304	WELLNESS	0	131,297	193.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-228,272	27,652,941	200.00

RECLASSIFICATIONS

Provider CCN: 14-1315

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

Worksheet A-6

Date/Time Prepared:
4/28/2021 12:36 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	10,000	1.00	
	0		0	10,000		
	B - RECLASS UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	43,773	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	
	0		0	43,773		
	C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	108,042	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	
	0		0	108,042		
	E - RECLASS INFECTION CONTROL SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	75,192	0	1.00	
	0		75,192	0		
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE					
1.00	OPERATING ROOM	50.00	0	3,951	1.00	
	0		0	3,951		
	H - RECLASS CRNA COSTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	34,945	0	1.00	
	0		34,945	0		
	J - RECLASS SOCIAL WORKER SALARIES					
1.00	SOCIAL SERVICE	17.00	287,922	0	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	0		287,922	0		
	K - RECLASS BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	44,700	1.00	
	0		0	44,700		
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	13,693	8,104	1.00	
	0		13,693	8,104		
500.00	Grand Total: Increases		411,752	218,570	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1315

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

Worksheet A-6

Date/Time Prepared:
4/28/2021 12:36 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00		
	A - RECLASS PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	10,000	0	0	1.00
	0		10,000	0		
	B - RECLASS UTILITIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,240	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	142	0	2.00
3.00	OPERATING ROOM	50.00	0	675	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	155	0	4.00
5.00	LABORATORY	60.00	0	248	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	313	0	6.00
	0		0	43,773		
	C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	0	3,070	0	1.00
2.00	SUBPROVIDER - IPF	40.00	0	407	0	2.00
3.00	OPERATING ROOM	50.00	0	11,540	0	3.00
4.00	ANESTHESIOLOGY	53.00	0	663	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,599	0	5.00
6.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	20,700	0	6.00
7.00	LABORATORY	60.00	0	47,047	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	15,265	0	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	534	0	9.00
10.00	EMERGENCY	91.00	0	6,867	0	10.00
11.00	RURAL HEALTH CLINIC	88.00	0	350	0	11.00
	0		0	108,042		
	E - RECLASS INFECTION CONTROL SALARY					
1.00	NURSING ADMINISTRATION	13.00	75,192	0	0	1.00
	0		75,192	0		
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE					
1.00	ANESTHESIOLOGY	53.00	0	3,951	0	1.00
	0		0	3,951		
	H - RECLASS CRNA COSTS					
1.00	ANESTHESIOLOGY	53.00	34,945	0	0	1.00
	0		34,945	0		
	J - RECLASS SOCIAL WORKER SALARIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	74,760	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	73,756	0	0	2.00
3.00	SUBPROVIDER - IPF	40.00	66,958	0	0	3.00
4.00	SUBPROVIDER - IPF	40.00	72,448	0	0	4.00
	0		287,922	0		
	K - RECLASS BUILDING RENT					
1.00	WELLNESS	193.04	0	44,700	10	1.00
	0		0	44,700		
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE					
1.00	WELLNESS	193.04	13,693	8,104	0	1.00
	0		13,693	8,104		
500.00	Grand Total: Decreases		421,752	208,570		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	279,691	0	0	0	0	1.00	
2.00	Land Improvements	533,487	0	0	0	0	2.00	
3.00	Buildings and Fixtures	13,114,110	0	0	0	359,820	3.00	
4.00	Building Improvements	3,208,854	2,042,305	0	2,042,305	0	4.00	
5.00	Fixed Equipment	73,264	0	0	0	0	5.00	
6.00	Movable Equipment	7,721,477	671,754	0	671,754	436,577	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	24,930,883	2,714,059	0	2,714,059	796,397	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	24,930,883	2,714,059	0	2,714,059	796,397	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	279,691	0					1.00
2.00	Land Improvements	533,487	0					
3.00	Buildings and Fixtures	12,754,290	0					
4.00	Building Improvements	5,251,159	0					
5.00	Fixed Equipment	73,264	0					
6.00	Movable Equipment	7,956,654	0					
7.00	HIT designated Assets	0	0					
8.00	Subtotal (sum of lines 1-7)	26,848,545	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	26,848,545	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/28/2021 12:36 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	757,522	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	382,822	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,140,344	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	757,522				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	382,822				2.00
3.00	Total (sum of lines 1-2)	0	1,140,344				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/28/2021 12:36 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	18,005,449	0	18,005,449	0.693528	6,935	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,956,654	0	7,956,654	0.306472	3,065	2.00
3.00	Total (sum of lines 1-2)	25,962,103	0	25,962,103	1.000000	10,000	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	6,935	922,888	44,700	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,065	505,764	0	2.00
3.00	Total (sum of lines 1-2)	0	0	10,000	1,428,652	44,700	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	6,935	0	0	974,523	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,065	0	0	508,829	2.00
3.00	Total (sum of lines 1-2)	0	10,000	0	0	1,483,352	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1315

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

Worksheet A-8

Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-74,307	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-999,228			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,424,259			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-55,639	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		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	-50	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-16,911	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1315

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

Worksheet A-8

Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS SUPPLIES REVENUE	B	-8,677	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	CABLE TELEVISION	A	-3,308	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANEOUS EXPENSE	A	-4,000	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PUBLIC RELATIONS EXPENSES	A	-78,094	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ASSET RELIFING	A	165,366	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07	ASSET RELIFING	A	127,156	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08	COFFEE SHOP RECEIPTS	B	157	DIETARY	10.00	0	33.08
33.09	LOBBYING EXPENSE	A	-10,816	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MISCELLANEOUS	B	-13,286	DIETARY	10.00	0	33.10
33.11	MISCELLANEOUS	B	-180	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	MISCELLANEOUS	B	-38,166	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	ACCOUNTING FEES	B	-2,815	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	SALE OF MEDICAL RECORDS	B	-850	MEDICAL RECORDS & LIBRARY	16.00	0	33.14
33.15	LABORATORY EXPENSE	A	-111,641	RURAL HEALTH CLINIC	88.00	0	33.15
33.16	CT SCANNER DEPRECIATION ADJUSTMENT	A	-1,659	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	PHYSICIAN TAIL COVERAGE	A	-5,209	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	CONTRACT PHARMACY DISPENSING FEES	A	-22,428	DRUGS CHARGED TO PATIENTS	73.00	0	33.19
33.20	NURSE PRACTITIONER WAGES	A	-31,348	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	NURSE PRACTITIONER WAGES	A	-45,513	ONCOLOGY	73.01	0	33.21
33.22	NURSE PRACTITIONER WAGES	A	-300,857	EMERGENCY	91.00	0	33.22
33.23	NURSE PRACTITIONER BENEFITS	A	-120,228	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-228,272				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1315

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

Worksheet A-8-1

Date/Time Prepared:
4/28/2021 12:36 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,399,516	1,298,066	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	212,590	0	2.00
3.00	10.00	DIETARY	DIETICIAN	6,185	5,194	3.00
4.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	101,951	102,898	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	623,575	4.01
4.02	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	267,032	115,676	4.02
4.03	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	0	91,573	4.03
4.04	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	0	20,178	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE	0	14,295	4.05
4.06	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	80,175	36,000	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	INFORMATICS	0	6,642	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	CARE MANAGEMENT	0	11,913	4.08
4.09	60.00	LABORATORY	LABORATORY TESTS	135,546	491,567	4.09
4.10	65.01	SLEEP LAB	SLEEP STUDIES	28,030	38,446	4.10
4.11	30.00	ADULTS & PEDIATRICS	BIO-MED	52	110	4.11
4.12	40.00	SUBPROVIDER - IPF	BIO-MED	82	173	4.12
4.13	50.00	OPERATING ROOM	BIO-MED	550	1,155	4.13
4.14	65.00	RESPIRATORY THERAPY	BIO-MED	26	55	4.14
4.15	91.00	EMERGENCY	BIO-MED	480	1,008	4.15
4.16	192.00	PHYSICIANS' PRIVATE OFFICES	BIO-MED	52	110	4.16
4.17	65.01	SLEEP LAB	BIO-MED	52	110	4.17
4.18	50.00	OPERATING ROOM	BIO-MED	957	2,009	4.18
4.19	88.00	RURAL HEALTH CLINIC	BIO-MED	26	55	4.19
4.20	60.00	LABORATORY	BIO-MED	339	713	4.20
4.21	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED	11,179	23,468	4.21
4.22	73.00	DRUGS CHARGED TO PATIENTS	BIO-MED	157	330	4.22
4.23	6.00	MAINTENANCE & REPAIRS	BIO-MED	14,278	29,975	4.23
4.24	30.00	ADULTS & PEDIATRICS	TELEMETRY SERVICES	17,481	11,010	4.24
4.25	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER	74,019	0	4.25
4.26	91.00	EMERGENCY	ER PHYSICIAN	195,826	193,463	4.26
4.27	2.00	CAP REL COSTS-MVBLE EQUIP	TELEMEDICINE ROBOT	5,965	8,520	4.27
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,552,546	3,128,287	5.00

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

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

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

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

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

6.00	B		0.00	BLESS CORP SVCS	0.00	6.00
7.00	G		0.00	BLESSING HOSP	0.00	7.00
8.00	G		0.00	DENMAN SERVICES	0.00	8.00
9.00	G		0.00	DENMAN SERVICES	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				100.00

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

Provider CCN: 14-1315

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

Worksheet A-8-1

Date/Time Prepared:
4/28/2021 12:36 pm

	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

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

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

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

Provider CCN: 14-1315

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

Worksheet A-8-1

Date/Time Prepared:
4/28/2021 12:36 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	2,101,450	0		1.00
2.00	212,590	0		2.00
3.00	991	0		3.00
4.00	-947	0		4.00
4.01	-623,575	0		4.01
4.02	151,356	0		4.02
4.03	-91,573	0		4.03
4.04	-20,178	0		4.04
4.05	-14,295	0		4.05
4.06	44,175	0		4.06
4.07	-6,642	0		4.07
4.08	-11,913	0		4.08
4.09	-356,021	0		4.09
4.10	-10,416	0		4.10
4.11	-58	0		4.11
4.12	-91	0		4.12
4.13	-605	0		4.13
4.14	-29	0		4.14
4.15	-528	0		4.15
4.16	-58	0		4.16
4.17	-58	0		4.17
4.18	-1,052	0		4.18
4.19	-29	0		4.19
4.20	-374	0		4.20
4.21	-12,289	0		4.21
4.22	-173	0		4.22
4.23	-15,697	0		4.23
4.24	6,471	0		4.24
4.25	74,019	9		4.25
4.26	2,363	0		4.26
4.27	-2,555	9		4.27
5.00	1,424,259			5.00

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

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	LAUNDRY		8.00
9.00	BIO-MED		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1315

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

Worksheet A-8-2

Date/Time Prepared:
4/28/2021 12:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	24,214	0	24,214	0	0	1.00
2.00	73.01	ONCOLOGY	24,417	24,417	0	0	0	2.00
3.00	91.00	EMERGENCY	2,620,500	968,616	1,651,884	0	0	3.00
4.00	91.00	EMERGENCY	12,150	0	12,150	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	2,450	0	2,450	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	4,200	0	4,200	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	351	0	351	0	0	7.00
8.00	50.00	OPERATING ROOM	6,195	6,195	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			2,694,477	999,228	1,695,249		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	73.01	ONCOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	73.01	ONCOLOGY	0	0	0	24,417		2.00
3.00	91.00	EMERGENCY	0	0	0	968,616		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	0		5.00
6.00	40.00	SUBPROVIDER - IPF	0	0	0	0		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		7.00
8.00	50.00	OPERATING ROOM	0	0	0	6,195		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	999,228		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/28/2021 12:36 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					231	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	525.63	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	85.92	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)	42.96	42.96	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					45,162	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)					45,162	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)					45,162	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)					85.92	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					67,018	22.00
23.00	Total salary equivalency (see instructions)					67,018	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					9,924	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,924	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)					797	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,721	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)					10,721	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/28/2021 12:36 pm		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		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)	85.92	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)						67,018	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						10,721	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)						77,739	63.00
64.00	Total cost of outside supplier services (from your records)						49,935	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						9,924	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						797	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						10,721	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						797	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						797	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/28/2021 12:36 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					72	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	103.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	81.43	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)	40.72	40.72	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					8,448	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					8,448	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					8,448	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)					81.43	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					63,515	22.00
23.00	Total salary equivalency (see instructions)					63,515	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)					2,932	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)					2,932	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)					248	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,180	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)					3,180	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: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/28/2021 12:36 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.43	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)						63,515
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						3,180
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0
60.00	Overtime allowance (from column 5, line 56)						0
61.00	Equipment cost (see instructions)						0
62.00	Supplies (see instructions)						0
63.00	Total allowance (sum of lines 57-62)						66,695
64.00	Total cost of outside supplier services (from your records)						8,693
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						2,932
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						248
100.02	Line 33 = line 28 = sum of lines 26 and 27						3,180
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						248
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
101.02	Line 34 = sum of lines 27 and 31						248
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
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
102.02	Line 35 = sum of lines 31 and 32						0

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/28/2021 12:36 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					61	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	71.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.25	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)	39.13	39.13	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					5,556	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)					5,556	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)					5,556	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)					78.25	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					61,035	22.00
23.00	Total salary equivalency (see instructions)					61,035	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)					2,387	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)					2,387	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)					210	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,597	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)					2,597	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1315		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/28/2021 12:36 pm		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.25	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)						61,035	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						2,597	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)						63,632	63.00
64.00	Total cost of outside supplier services (from your records)						4,315	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						2,387	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						210	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						2,597	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						210	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						210	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	974,523	974,523			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	508,829		508,829		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,953,316	0	0	2,953,316	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,281,999	248,423	138,113	510,995	7,179,530
6.00	00600	MAINTENANCE & REPAIRS	858,083	170,253	94,652	123,344	1,246,332
7.00	00700	OPERATION OF PLANT	486,036	0	0	0	486,036
8.00	00800	LAUNDRY & LINEN SERVICE	39,646	7,510	4,175	0	51,331
9.00	00900	HOUSEKEEPING	480,415	16,147	8,977	89,443	594,982
10.00	01000	DIETARY	297,734	15,381	8,551	61,022	382,688
11.00	01100	CAFETERIA	0	4,361	2,424	0	6,785
13.00	01300	NURSING ADMINISTRATION	173,457	1,465	814	47,558	223,294
16.00	01600	MEDICAL RECORDS & LIBRARY	287,846	10,566	5,874	10,350	314,636
17.00	01700	SOCIAL SERVICE	287,922	1,052	585	80,351	369,910
19.00	01900	NONPHYSICIAN ANESTHETISTS	34,945	0	0	9,752	44,697
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,044,292	58,788	32,683	224,806	1,360,569
40.00	04000	SUBPROVIDER - IPF	927,846	46,926	26,089	220,455	1,221,316
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	546,921	45,141	25,097	128,296	745,455
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,312,530	28,666	15,937	278,379	1,635,512
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	77,978	3,704	2,059	19,723	103,464
60.00	06000	LABORATORY	1,098,415	16,795	9,337	145,742	1,270,289
65.00	06500	RESPIRATORY THERAPY	54,994	9,774	5,434	8,717	78,919
65.01	03610	SLEEP LAB	28,351	1,061	590	75	30,077
66.00	06600	PHYSICAL THERAPY	49,934	0	0	0	49,934
67.00	06700	OCCUPATIONAL THERAPY	68,145	0	0	16,020	84,165
68.00	06800	SPEECH PATHOLOGY	27,815	0	0	6,558	34,373
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	383,620	7,190	3,997	18,658	413,465
73.00	07300	DRUGS CHARGED TO PATIENTS	3,183,680	11,407	6,342	120,757	3,322,186
73.01	03480	ONCOLOGY	72,254	26,039	14,477	19,102	131,872
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,741,259	48,913	27,193	385,487	2,202,852
91.00	09100	EMERGENCY	2,632,351	42,431	23,589	251,371	2,949,742
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,915,136	821,993	456,989	2,776,961	26,534,411
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	105,895	26,182	14,556	18,684	165,317
192.01	19201	XPRESS CARE	500,613	0	9,066	126,816	636,495
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	RENAL	0	14,539	0	0	14,539
193.02	19302	LEASED SPACE	0	56,902	0	0	56,902
193.03	19303	UNUSED SPACE	0	4,150	0	0	4,150
193.04	19304	WELLNESS	131,297	50,757	28,218	30,855	241,127
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	27,652,941	974,523	508,829	2,953,316	27,652,941

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,179,530					5.00
6.00	00600	MAINTENANCE & REPAIRS	437,059	1,683,391				6.00
7.00	00700	OPERATION OF PLANT	170,441	0	656,477			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,001	22,256	8,869	100,457		8.00
9.00	00900	HOUSEKEEPING	208,646	47,855	19,070	0	870,553	9.00
10.00	01000	DIETARY	134,199	45,585	18,166	0	24,598	10.00
11.00	01100	CAFETERIA	2,379	12,924	5,150	0	6,974	11.00
13.00	01300	NURSING ADMINISTRATION	78,304	4,341	1,730	0	2,343	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110,335	31,313	12,478	0	16,897	16.00
17.00	01700	SOCIAL SERVICE	129,719	3,119	1,243	0	1,683	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	15,674	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	477,119	174,230	69,432	38,028	94,020	30.00
40.00	04000	SUBPROVIDER - IPF	428,286	139,075	55,421	62,429	75,047	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	261,413	133,785	53,314	0	72,193	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,535	84,957	33,855	0	45,844	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	36,282	10,978	4,375	0	5,924	54.01
60.00	06000	LABORATORY	445,460	49,776	19,836	0	26,860	60.00
65.00	06500	RESPIRATORY THERAPY	27,675	28,968	11,544	0	15,631	65.00
65.01	03610	SLEEP LAB	10,547	3,144	1,253	0	1,696	65.01
66.00	06600	PHYSICAL THERAPY	17,511	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,515	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,054	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,992	21,308	8,491	0	11,498	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,165,008	33,808	13,473	0	18,243	73.00
73.01	03480	ONCOLOGY	46,244	77,172	30,753	0	41,643	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	772,487	144,963	57,768	0	78,224	88.00
91.00	09100	EMERGENCY	1,034,404	125,751	50,112	0	67,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,787,289	1,195,308	476,333	100,457	607,175	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,973	77,596	30,922	0	41,872	192.00
192.01	19201	XPRESS CARE	223,204	48,329	0	0	26,079	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	5,098	43,090	17,171	0	23,252	193.01
193.02	19302	LEASED SPACE	19,954	168,641	67,204	0	91,002	193.02
193.03	19303	UNUSED SPACE	1,455	0	4,902	0	0	193.03
193.04	19304	WELLNESS	84,557	150,427	59,945	0	81,173	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,179,530	1,683,391	656,477	100,457	870,553	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	605,236					10.00
11.00	01100	CAFETERIA	0	34,212				11.00
13.00	01300	NURSING ADMINISTRATION	0	809	310,821			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	176	0	485,835		16.00
17.00	01700	SOCIAL SERVICE	0	1,367	0	0	507,041	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	166	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	229,112	3,825	82,042	22,780	191,940	30.00
40.00	04000	SUBPROVIDER - IPF	376,124	3,751	53,550	32,851	315,101	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,183	34,393	15,588	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	564	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,736	11,213	168,097	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	336	0	5,497	0	54.01
60.00	06000	LABORATORY	0	2,480	0	84,650	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	148	0	4,638	0	65.00
65.01	03610	SLEEP LAB	0	1	0	3,320	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,809	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	273	0	3,019	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	112	0	520	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	317	1,277	11,123	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,055	0	76,172	0	73.00
73.01	03480	ONCOLOGY	0	325	5,188	3,752	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	6,557	32,022	0	0	88.00
91.00	09100	EMERGENCY	0	4,277	82,982	51,455	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)	605,236	33,894	302,667	485,835	507,041	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	318	5,462	0	0	192.00
192.01	19201	XPRESS CARE	0	0	2,692	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	605,236	34,212	310,821	485,835	507,041	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	60,537				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,743,097	0	2,743,097	30.00
40.00	04000	SUBPROVIDER - IPF	0	2,762,951	0	2,762,951	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,318,324	0	1,318,324	50.00
53.00	05300	ANESTHESIOLOGY	60,537	61,101	0	61,101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,557,749	0	2,557,749	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	166,856	0	166,856	54.01
60.00	06000	LABORATORY	0	1,899,351	0	1,899,351	60.00
65.00	06500	RESPIRATORY THERAPY	0	167,523	0	167,523	65.00
65.01	03610	SLEEP LAB	0	50,038	0	50,038	65.01
66.00	06600	PHYSICAL THERAPY	0	69,254	0	69,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	116,972	0	116,972	67.00
68.00	06800	SPEECH PATHOLOGY	0	47,059	0	47,059	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	612,471	0	612,471	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,630,945	0	4,630,945	73.00
73.01	03480	ONCOLOGY	0	336,949	0	336,949	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,294,873	0	3,294,873	88.00
91.00	09100	EMERGENCY	0	4,366,580	0	4,366,580	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)	60,537	25,202,093	0	25,202,093	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	379,460	0	379,460	192.00
192.01	19201	XPRESS CARE	0	936,799	0	936,799	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	0	103,150	0	103,150	193.01
193.02	19302	LEASED SPACE	0	403,703	0	403,703	193.02
193.03	19303	UNUSED SPACE	0	10,507	0	10,507	193.03
193.04	19304	WELLNESS	0	617,229	0	617,229	193.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	60,537	27,652,941	0	27,652,941	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	248,423	138,113	386,536	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	170,253	94,652	264,905	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,510	4,175	11,685	8.00
9.00	00900	HOUSEKEEPING	0	16,147	8,977	25,124	9.00
10.00	01000	DIETARY	0	15,381	8,551	23,932	10.00
11.00	01100	CAFETERIA	0	4,361	2,424	6,785	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,465	814	2,279	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,566	5,874	16,440	16.00
17.00	01700	SOCIAL SERVICE	0	1,052	585	1,637	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	58,788	32,683	91,471	30.00
40.00	04000	SUBPROVIDER - IPF	0	46,926	26,089	73,015	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	45,141	25,097	70,238	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,666	15,937	44,603	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	3,704	2,059	5,763	54.01
60.00	06000	LABORATORY	0	16,795	9,337	26,132	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,774	5,434	15,208	65.00
65.01	03610	SLEEP LAB	0	1,061	590	1,651	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,190	3,997	11,187	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,407	6,342	17,749	73.00
73.01	03480	ONCOLOGY	0	26,039	14,477	40,516	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	48,913	27,193	76,106	88.00
91.00	09100	EMERGENCY	0	42,431	23,589	66,020	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	821,993	456,989	1,278,982	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		26,182	14,556	40,738	192.00
192.01	19201	XPRESS CARE	22,980	0	9,066	32,046	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	0	14,539	0	14,539	193.01
193.02	19302	LEASED SPACE	0	56,902	0	56,902	193.02
193.03	19303	UNUSED SPACE	0	4,150	0	4,150	193.03
193.04	19304	WELLNESS	0	50,757	28,218	78,975	193.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,980	974,523	508,829	1,506,332	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	386,536					5.00
6.00	00600	MAINTENANCE & REPAIRS	23,531	288,436				6.00
7.00	00700	OPERATION OF PLANT	9,176	0	9,176			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	969	3,813	124	16,591		8.00
9.00	00900	HOUSEKEEPING	11,233	8,200	267	0	44,824	9.00
10.00	01000	DIETARY	7,225	7,811	254	0	1,267	10.00
11.00	01100	CAFETERIA	128	2,214	72	0	359	11.00
13.00	01300	NURSING ADMINISTRATION	4,216	744	24	0	121	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,940	5,365	174	0	870	16.00
17.00	01700	SOCIAL SERVICE	6,984	534	17	0	87	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	844	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,688	29,853	972	6,281	4,840	30.00
40.00	04000	SUBPROVIDER - IPF	23,058	23,829	775	10,310	3,864	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,074	22,923	745	0	3,717	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,878	14,557	473	0	2,360	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,953	1,881	61	0	305	54.01
60.00	06000	LABORATORY	23,983	8,529	277	0	1,383	60.00
65.00	06500	RESPIRATORY THERAPY	1,490	4,963	161	0	805	65.00
65.01	03610	SLEEP LAB	568	539	18	0	87	65.01
66.00	06600	PHYSICAL THERAPY	943	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,589	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	649	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,806	3,651	119	0	592	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,724	5,793	188	0	939	73.00
73.01	03480	ONCOLOGY	2,490	13,223	430	0	2,144	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	41,590	24,838	807	0	4,028	88.00
91.00	09100	EMERGENCY	55,691	21,546	700	0	3,494	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)	365,420	204,806	6,658	16,591	31,262	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,121	13,296	432	0	2,156	192.00
192.01	19201	XPRESS CARE	12,017	8,281	0	0	1,343	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	274	7,383	240	0	1,197	193.01
193.02	19302	LEASED SPACE	1,074	28,895	939	0	4,686	193.02
193.03	19303	UNUSED SPACE	78	0	69	0	0	193.03
193.04	19304	WELLNESS	4,552	25,775	838	0	4,180	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	386,536	288,436	9,176	16,591	44,824	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	40,489					10.00
11.00	01100	CAFETERIA	0	9,558				11.00
13.00	01300	NURSING ADMINISTRATION	0	226	7,610			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49	0	28,838		16.00
17.00	01700	SOCIAL SERVICE	0	382	0	0	9,641	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	46	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,327	1,068	2,009	1,353	3,650	30.00
40.00	04000	SUBPROVIDER - IPF	25,162	1,047	1,311	1,951	5,991	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	610	842	926	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	33	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,323	275	9,970	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	94	0	326	0	54.01
60.00	06000	LABORATORY	0	692	0	5,027	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	41	0	275	0	65.00
65.01	03610	SLEEP LAB	0	0	0	197	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	107	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	76	0	179	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	31	0	31	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	89	31	661	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	574	0	4,523	0	73.00
73.01	03480	ONCOLOGY	0	91	127	223	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,836	784	0	0	88.00
91.00	09100	EMERGENCY	0	1,194	2,031	3,056	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)	40,489	9,469	7,410	28,838	9,641	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	89	134	0	0	192.00
192.01	19201	XPRESS CARE	0	0	66	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,489	9,558	7,610	28,838	9,641	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	890				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		182,512	0	182,512	30.00
40.00	04000	SUBPROVIDER - IPF		170,313	0	170,313	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		114,075	0	114,075	50.00
53.00	05300	ANESTHESIOLOGY		33	0	33	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		104,439	0	104,439	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		10,383	0	10,383	54.01
60.00	06000	LABORATORY		66,023	0	66,023	60.00
65.00	06500	RESPIRATORY THERAPY		22,943	0	22,943	65.00
65.01	03610	SLEEP LAB		3,060	0	3,060	65.01
66.00	06600	PHYSICAL THERAPY		1,050	0	1,050	66.00
67.00	06700	OCCUPATIONAL THERAPY		1,844	0	1,844	67.00
68.00	06800	SPEECH PATHOLOGY		711	0	711	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		24,136	0	24,136	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		92,490	0	92,490	73.00
73.01	03480	ONCOLOGY		59,244	0	59,244	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		149,989	0	149,989	88.00
91.00	09100	EMERGENCY		153,732	0	153,732	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	1,156,977	0	1,156,977	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		59,966	0	59,966	192.00
192.01	19201	XPRESS CARE		53,753	0	53,753	192.01
193.00	19300	NONPAID WORKERS		0	0	0	193.00
193.01	19301	RENAL		23,633	0	23,633	193.01
193.02	19302	LEASED SPACE		92,496	0	92,496	193.02
193.03	19303	UNUSED SPACE		4,297	0	4,297	193.03
193.04	19304	WELLNESS		114,320	0	114,320	193.04
200.00		Cross Foot Adjustments	890	890	0	890	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	890	1,506,332	0	1,506,332	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1315

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MOVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	115,756				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		108,714			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,582,664		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,508	29,508	1,831,055	-7,179,530	5.00
6.00	00600	MAINTENANCE & REPAIRS	20,223	20,223	441,980	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	0	0	8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	320,502	0	9.00
10.00	01000	DIETARY	1,827	1,827	218,662	0	10.00
11.00	01100	CAFETERIA	518	518	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	170,414	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	37,086	0	16.00
17.00	01700	SOCIAL SERVICE	125	125	287,922	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	34,945	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	805,551	0	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	789,959	0	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,362	5,362	459,727	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	997,519	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	70,675	0	54.01
60.00	06000	LABORATORY	1,995	1,995	522,239	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	31,236	0	65.00
65.01	03610	SLEEP LAB	126	126	269	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	57,406	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	23,500	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	66,856	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	432,710	0	73.00
73.01	03480	ONCOLOGY	3,093	3,093	68,449	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	1,381,323	0	88.00
91.00	09100	EMERGENCY	5,040	5,040	900,743	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)	97,638	97,638	9,950,728	-7,179,530	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,110	3,110	66,949	0	192.00
192.01	19201	XPRESS CARE	0	1,937	454,423	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	RENAL	1,727	0	0	0	193.01
193.02	19302	LEASED SPACE	6,759	0	0	0	193.02
193.03	19303	UNUSED SPACE	493	0	0	0	193.03
193.04	19304	WELLNESS	6,029	6,029	110,564	0	193.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	974,523	508,829	2,953,316	7,179,530	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.418769	4.680437	0.279071	0.350676	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	386,536	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.018880	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1315

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	67,469					6.00
7.00	00700	OPERATION OF PLANT	0	66,025				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	2,676			8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	0	64,659		9.00
10.00	01000	DIETARY	1,827	1,827	0	1,827	2,676	10.00
11.00	01100	CAFETERIA	518	518	0	518	0	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	0	174	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	0	1,255	0	16.00
17.00	01700	SOCIAL SERVICE	125	125	0	125	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,983	6,983	1,013	6,983	1,013	30.00
40.00	04000	SUBPROVIDER - IPF	5,574	5,574	1,663	5,574	1,663	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,362	5,362	0	5,362	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	0	3,405	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	0	440	0	54.01
60.00	06000	LABORATORY	1,995	1,995	0	1,995	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	0	1,161	0	65.00
65.01	03610	SLEEP LAB	126	126	0	126	0	65.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	0	854	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	0	1,355	0	73.00
73.01	03480	ONCOLOGY	3,093	3,093	0	3,093	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	0	5,810	0	88.00
91.00	09100	EMERGENCY	5,040	5,040	0	5,040	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,907	47,907	2,676	45,097	2,676	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,110	3,110	0	3,110	0	192.00
192.01	19201	XPRESS CARE	1,937	0	0	1,937	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	1,727	1,727	0	1,727	0	193.01
193.02	19302	LEASED SPACE	6,759	6,759	0	6,759	0	193.02
193.03	19303	UNUSED SPACE	0	493	0	0	0	193.03
193.04	19304	WELLNESS	6,029	6,029	0	6,029	0	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,683,391	656,477	100,457	870,553	605,236	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.950585	9.942855	37.539985	13.463756	226.171898	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	288,436	9,176	16,591	44,824	40,489	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.275089	0.138978	6.199925	0.693237	15.130419	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1315

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

Worksheet B-1

Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	7,205,478					11.00
13.00	01300	NURSING ADMINISTRATION	170,414	2,542,570				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,086	0	59,367,094			16.00
17.00	01700	SOCIAL SERVICE	287,922	0	0	2,676		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	34,945	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	805,551	671,118	2,783,459	1,013	0	30.00
40.00	04000	SUBPROVIDER - IPF	789,959	438,050	4,014,082	1,663	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	459,727	281,338	1,904,634	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	68,867	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	997,519	91,728	20,542,819	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	70,675	0	671,695	0	0	54.01
60.00	06000	LABORATORY	522,239	0	10,343,307	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	31,236	0	566,697	0	0	65.00
65.01	03610	SLEEP LAB	269	0	405,653	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	221,095	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,406	0	368,920	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,500	0	63,598	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,856	10,446	1,359,105	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	432,710	0	9,307,471	0	0	73.00
73.01	03480	ONCOLOGY	68,449	42,439	458,401	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,381,323	261,943	0	0	0	88.00
91.00	09100	EMERGENCY	900,743	678,810	6,287,291	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,138,529	2,475,872	59,367,094	2,676	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	66,949	44,680	0	0	0	192.00
192.01	19201	XPRESS CARE	0	22,018	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	34,212	310,821	485,835	507,041	60,537	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004748	0.122247	0.008184	189.477205	605.370000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,558	7,610	28,838	9,641	890	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001326	0.002993	0.000486	3.602765	8.900000	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: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

			Title XVIII		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
					Total Costs	RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,743,097		2,743,097	0	2,743,097	30.00	
40.00	04000	SUBPROVIDER - IPF	2,762,951		2,762,951	0	2,762,951	40.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,318,324		1,318,324	0	1,318,324	50.00	
53.00	05300	ANESTHESIOLOGY	61,101		61,101	0	61,101	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,557,749		2,557,749	0	2,557,749	54.00	
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	166,856		166,856	0	166,856	54.01	
60.00	06000	LABORATORY	1,899,351		1,899,351	0	1,899,351	60.00	
65.00	06500	RESPIRATORY THERAPY	167,523	0	167,523	0	167,523	65.00	
65.01	03610	SLEEP LAB	50,038	0	50,038	0	50,038	65.01	
66.00	06600	PHYSICAL THERAPY	69,254	0	69,254	0	69,254	66.00	
67.00	06700	OCCUPATIONAL THERAPY	116,972	0	116,972	0	116,972	67.00	
68.00	06800	SPEECH PATHOLOGY	47,059	0	47,059	0	47,059	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	612,471		612,471	0	612,471	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,630,945		4,630,945	0	4,630,945	73.00	
73.01	03480	ONCOLOGY	336,949		336,949	0	336,949	73.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,294,873		3,294,873	0	3,294,873	88.00	
91.00	09100	EMERGENCY	4,366,580		4,366,580	0	4,366,580	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	501,515		501,515		501,515	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	25,703,608	0	25,703,608	0	25,703,608	200.00	
201.00		Less Observation Beds	501,515		501,515		501,515	201.00	
202.00		Total (see instructions)	25,202,093	0	25,202,093	0	25,202,093	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,065,812		2,065,812			30.00
40.00	04000	SUBPROVIDER - IPF	4,014,082		4,014,082			40.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,036	1,891,598	1,904,634	0.692167	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	68,867	68,867	0.887232	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	895,634	19,647,185	20,542,819	0.124508	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	13,955	657,740	671,695	0.248410	0.000000	54.01
60.00	06000	LABORATORY	1,318,818	9,024,489	10,343,307	0.183631	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	283,520	283,177	566,697	0.295613	0.000000	65.00
65.01	03610	SLEEP LAB	0	405,653	405,653	0.123352	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	213,006	8,089	221,095	0.313232	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	349,101	19,819	368,920	0.317066	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,818	42,780	63,598	0.739945	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	232,313	1,126,792	1,359,105	0.450643	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	908,314	8,903,211	9,811,525	0.471990	0.000000	73.00
73.01	03480	ONCOLOGY	0	458,401	458,401	0.735053	0.000000	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,983,976	2,983,976			88.00
91.00	09100	EMERGENCY	21,924	6,265,367	6,287,291	0.694509	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	717,647	717,647	0.698832	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,350,333	52,504,791	62,855,124			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,350,333	52,504,791	62,855,124			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.692167			50.00
53.00	05300	ANESTHESIOLOGY	0.887232			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124508			54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.248410			54.01
60.00	06000	LABORATORY	0.183631			60.00
65.00	06500	RESPIRATORY THERAPY	0.295613			65.00
65.01	03610	SLEEP LAB	0.123352			65.01
66.00	06600	PHYSICAL THERAPY	0.313232			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.317066			67.00
68.00	06800	SPEECH PATHOLOGY	0.739945			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.450643			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.471990			73.00
73.01	03480	ONCOLOGY	0.735053			73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.694509			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.698832			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/28/2021 12:36 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	114,075	1,904,634	0.059893	7,821	468
53.00	05300	ANESTHESIOLOGY	33	68,867	0.000479	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,439	20,542,819	0.005084	323,205	1,643
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	10,383	671,695	0.015458	9,764	151
60.00	06000	LABORATORY	66,023	10,343,307	0.006383	398,203	2,542
65.00	06500	RESPIRATORY THERAPY	22,943	566,697	0.040485	115,918	4,693
65.01	03610	SLEEP LAB	3,060	405,653	0.007543	0	0
66.00	06600	PHYSICAL THERAPY	1,050	221,095	0.004749	33,663	160
67.00	06700	OCCUPATIONAL THERAPY	1,844	368,920	0.004998	80,081	400
68.00	06800	SPEECH PATHOLOGY	711	63,598	0.011180	10,030	112
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,136	1,359,105	0.017759	95,508	1,696
73.00	07300	DRUGS CHARGED TO PATIENTS	92,490	9,811,525	0.009427	236,195	2,227
73.01	03480	ONCOLOGY	59,244	458,401	0.129241	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	149,989	2,983,976	0.050265	0	0
91.00	09100	EMERGENCY	153,732	6,287,291	0.024451	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	33,368	717,647	0.046496	0	0
200.00		Total (lines 50 through 199)	837,520	56,775,230		1,310,388	14,092

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315

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

Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	60,537	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	60,537	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315

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

Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	1,904,634	0.000000
53.00	05300	ANESTHESIOLOGY	0	60,537	0	68,867	0.879042
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,542,819	0.000000
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	671,695	0.000000
60.00	06000	LABORATORY	0	0	0	10,343,307	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	566,697	0.000000
65.01	03610	SLEEP LAB	0	0	0	405,653	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	221,095	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	368,920	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	63,598	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,359,105	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,811,525	0.000000
73.01	03480	ONCOLOGY	0	0	0	458,401	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,983,976	0.000000
91.00	09100	EMERGENCY	0	0	0	6,287,291	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	717,647	0.000000
200.00		Total (lines 50 through 199)	0	60,537	0	56,775,230	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 12:36 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	7,821	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	323,205	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	9,764	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	398,203	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	115,918	0	0	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	33,663	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	80,081	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,030	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	95,508	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	236,195	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,310,388	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/28/2021 12:36 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.692167	0	795,951	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.887232	0	8,288	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124508	0	8,191,194	0	0	54.00	
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.248410	0	322,655	0	0	54.01	
60.00	06000	LABORATORY	0.183631	0	3,504,631	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.295613	0	116,224	0	0	65.00	
65.01	03610	SLEEP LAB	0.123352	0	216,134	0	0	65.01	
66.00	06600	PHYSICAL THERAPY	0.313232	0	3,295	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.317066	0	7,385	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.739945	0	17,687	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.450643	0	526,919	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.471990	0	4,451,873	25,385	0	73.00	
73.01	03480	ONCOLOGY	0.735053	0	252,486	0	0	73.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00	
91.00	09100	EMERGENCY	0.694509	0	2,136,082	3,190	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.698832	0	427,220	0	0	92.00	
200.00		Subtotal (see instructions)		0	20,978,024	28,575	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	20,978,024	28,575	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 4/28/2021 12:36 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	550,931	0		50.00
53.00	05300	ANESTHESIOLOGY	7,353	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,019,869	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	80,151	0		54.01
60.00	06000	LABORATORY	643,559	0		60.00
65.00	06500	RESPIRATORY THERAPY	34,357	0		65.00
65.01	03610	SLEEP LAB	26,661	0		65.01
66.00	06600	PHYSICAL THERAPY	1,032	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,342	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,087	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	237,452	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,101,240	11,981		73.00
73.01	03480	ONCOLOGY	185,591	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	1,483,528	2,215		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	298,555	0		92.00
200.00		Subtotal (see instructions)	6,685,708	14,196		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,685,708	14,196		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part II Date/Time Prepared: 4/28/2021 12:36 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		114,075	1,904,634	0.059893	4,100	246	50.00
53.00	05300	ANESTHESIOLOGY		33	68,867	0.000479	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		104,439	20,542,819	0.005084	154,454	785	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		10,383	671,695	0.015458	0	0	54.01
60.00	06000	LABORATORY		66,023	10,343,307	0.006383	291,343	1,860	60.00
65.00	06500	RESPIRATORY THERAPY		22,943	566,697	0.040485	5,332	216	65.00
65.01	03610	SLEEP LAB		3,060	405,653	0.007543	0	0	65.01
66.00	06600	PHYSICAL THERAPY		1,050	221,095	0.004749	5,651	27	66.00
67.00	06700	OCCUPATIONAL THERAPY		1,844	368,920	0.004998	24,447	122	67.00
68.00	06800	SPEECH PATHOLOGY		711	63,598	0.011180	836	9	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		24,136	1,359,105	0.017759	14,930	265	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		92,490	9,811,525	0.009427	151,092	1,424	73.00
73.01	03480	ONCOLOGY		59,244	458,401	0.129241	0	0	73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		149,989	2,983,976	0.050265	0	0	88.00
91.00	09100	EMERGENCY		153,732	6,287,291	0.024451	21,629	529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	717,647	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		804,152	56,775,230		673,814	5,483	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315
Component CCN: 14-M315

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

Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 12:36 pm

			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	60,537	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	60,537	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1315
Component CCN: 14-M315

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

Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 12:36 pm

Title XVIII			Subprovider - IPF		PPS	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	1,904,634	0.000000	50.00
53.00 05300 ANESTHESIOLOGY	0	60,537	0	68,867	0.879042	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	20,542,819	0.000000	54.00
54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	671,695	0.000000	54.01
60.00 06000 LABORATORY	0	0	0	10,343,307	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	566,697	0.000000	65.00
65.01 03610 SLEEP LAB	0	0	0	405,653	0.000000	65.01
66.00 06600 PHYSICAL THERAPY	0	0	0	221,095	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	368,920	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	63,598	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,359,105	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	9,811,525	0.000000	73.00
73.01 03480 ONCOLOGY	0	0	0	458,401	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	2,983,976	0.000000	88.00
91.00 09100 EMERGENCY	0	0	0	6,287,291	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	717,647	0.000000	92.00
200.00 Total (lines 50 through 199)	0	60,537	0	56,775,230		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 12:36 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	4,100	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	154,454	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY		0.000000	291,343	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	5,332	0	0	0	65.00
65.01	03610	SLEEP LAB		0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0.000000	5,651	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	24,447	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	836	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	14,930	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	151,092	0	0	0	73.00
73.01	03480	ONCOLOGY		0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY		0.000000	21,629	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			673,814	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315

Period:

Worksheet D

Component CCN: 14-M315

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
4/28/2021 12:36 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Charges			Costs	
			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.692167	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.887232	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124508	0	0	0	0 54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.248410	0	0	0	0 54.01
60.00	06000	LABORATORY	0.183631	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.295613	0	0	0	0 65.00
65.01	03610	SLEEP LAB	0.123352	0	0	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.313232	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.317066	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.739945	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.450643	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.471990	0	0	1,747	0 73.00
73.01	03480	ONCOLOGY	0.735053	0	0	0	0 73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC					88.00
91.00	09100	EMERGENCY	0.694509	0	0	210	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.698832	0	0	0	0 92.00
200.00		Subtotal (see instructions)		0	0	1,957	0 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	1,957	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 4/28/2021 12:36 pm
			Title XVIII		Subprovider - IPF	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	825		73.00
73.01	03480	ONCOLOGY	0	0		73.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0	146		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	971		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	971		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 12:36 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,201	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		864	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)		656	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		67	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)		202	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		22	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)		46	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		447	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)		67	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)		202	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		159.96	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		168.89	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,743,097	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)		3,519	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)		7,769	25.00
26.00	Total swing-bed cost (see instructions)		659,882	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,083,215	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)		2,083,215	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,411.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,077,775	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)		1,077,775	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315

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

Worksheet D-1

Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					353,348	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,431,123	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)					161,546	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					487,048	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					648,594	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)					208	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,411.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					501,515	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1315

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

Worksheet D-1

Date/Time Prepared:
4/28/2021 12:36 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	182,512	2,743,097	0.066535	501,515	33,368	90.00
91.00	Nursing School cost	0	2,743,097	0.000000	501,515	0	91.00
92.00	Allied health cost	0	2,743,097	0.000000	501,515	0	92.00
93.00	All other Medical Education	0	2,743,097	0.000000	501,515	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 12:36 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,663	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,663	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)		1,663	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		788	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,762,951	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,762,951	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)		2,762,951	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)		1,661.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,309,207	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)		1,309,207	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 12:36 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					180,349 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,489,556 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,483 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					5,483 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,484,073 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1315 Component CCN: 14-M315		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/28/2021 12:36 pm
			Title XVIII		Subprovider - IPF		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	2,762,951	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,762,951	0.000000	0	0	91.00
92.00	Allied health cost	0	2,762,951	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,762,951	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/28/2021 12:36 pm	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,168,179		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.692167	7,821	5,413	50.00
53.00	05300	ANESTHESIOLOGY	0.887232	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124508	323,205	40,242	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.248410	9,764	2,425	54.01
60.00	06000	LABORATORY	0.183631	398,203	73,122	60.00
65.00	06500	RESPIRATORY THERAPY	0.295613	115,918	34,267	65.00
65.01	03610	SLEEP LAB	0.123352	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.313232	33,663	10,544	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.317066	80,081	25,391	67.00
68.00	06800	SPEECH PATHOLOGY	0.739945	10,030	7,422	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.450643	95,508	43,040	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.471990	236,195	111,482	73.00
73.01	03480	ONCOLOGY	0.735053	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.694509	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.698832	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,310,388	353,348	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)		1,310,388		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/28/2021 12:36 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
40.00	04000 SUBPROVIDER - IPF		1,897,988		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.692167	4,100	2,838	50.00
53.00	05300 ANESTHESIOLOGY	0.887232	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124508	154,454	19,231	54.00
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.248410	0	0	54.01
60.00	06000 LABORATORY	0.183631	291,343	53,500	60.00
65.00	06500 RESPIRATORY THERAPY	0.295613	5,332	1,576	65.00
65.01	03610 SLEEP LAB	0.123352	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.313232	5,651	1,770	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.317066	24,447	7,751	67.00
68.00	06800 SPEECH PATHOLOGY	0.739945	836	619	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.450643	14,930	6,728	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.471990	151,092	71,314	73.00
73.01	03480 ONCOLOGY	0.735053	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.694509	21,629	15,022	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.698832	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		673,814	180,349	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)		673,814		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1315 Component CCN: 14-Z315	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/28/2021 12:36 pm	
Cost Center Description			Title XVIII	Swing Beds - SNF	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.692167	597	413	50.00
53.00	05300	ANESTHESIOLOGY	0.887232	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124508	15,933	1,984	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.248410	0	0	54.01
60.00	06000	LABORATORY	0.183631	80,120	14,713	60.00
65.00	06500	RESPIRATORY THERAPY	0.295613	20,007	5,914	65.00
65.01	03610	SLEEP LAB	0.123352	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.313232	116,487	36,487	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.317066	152,294	48,287	67.00
68.00	06800	SPEECH PATHOLOGY	0.739945	4,046	2,994	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.450643	23,668	10,666	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.471990	166,082	78,389	73.00
73.01	03480	ONCOLOGY	0.735053	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.694509	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.698832	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		579,234	199,847	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)		579,234		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/28/2021 12:36 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,699,904	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)		6,699,904	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		6,766,903	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)		28,141	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,482,985	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,255,777	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,255,777	30.00
31.00	Primary payer payments		84	31.00
32.00	Subtotal (line 30 minus line 31)		3,255,693	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)		544,777	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		354,105	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		520,864	36.00
37.00	Subtotal (see instructions)		3,609,798	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,609,798	40.00
40.01	Sequestration adjustment (see instructions)		41,874	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		3,710,718	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)		-142,794	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/28/2021 12:36 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		971	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		172	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)		971	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,957	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)		1,957	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)		1,957	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		986	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)		971	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)		172	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,143	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,143	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,143	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,143	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,143	40.00
40.01	Sequestration adjustment (see instructions)		13	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		1,059	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)		71	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: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/28/2021 12:36 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,450,992		3,520,677	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	04/08/2020	36,538	04/08/2020	72,743	3.01
3.02		09/14/2020	27,335	09/14/2020	117,298	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		63,873		190,041	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)		1,514,865		3,710,718	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		204,124		142,794	6.02
7.00	Total Medicare program liability (see instructions)		1,310,741		3,567,924	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-1315
 Component CCN: 14-M315

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 4/28/2021 12:36 pm

		Title XVIII		Subprovider - IPF		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		735,142		1,059	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		735,142		1,059	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		21,880		71	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		757,022		1,130	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 4/28/2021 12:36 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		886,537		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	04/08/2020	3,840		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,840		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)		890,377		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		43,735		0	6.02	
7.00	Total Medicare program liability (see instructions)		846,642		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part II
Date/Time Prepared:
4/28/2021 12:36 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1315 Component CCN: 14-Z315	Period: From 10/01/2019 To 09/30/2020	Worksheet E-2 Date/Time Prepared: 4/28/2021 12:36 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)	655,080	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)	201,845	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	269	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)	856,925	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	856,925	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)	856,925	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	347	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	856,578	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)	856,578	0	19.00
19.01	Sequestration adjustment (see instructions)	9,936	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	890,377	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)	-43,735	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: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 4/28/2021 12:36 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,431,123	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,431,123	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,445,434	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,445,434	19.00
20.00	Deductibles (exclude professional component)		144,936	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,300,498	22.00
23.00	Coinsurance		1,408	23.00
24.00	Subtotal (line 22 minus line 23)		1,299,090	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		41,590	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		27,034	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,230	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,326,124	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)		1,326,124	30.00
30.01	Sequestration adjustment (see instructions)		15,383	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		1,514,865	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)		-204,124	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1315 Component CCN: 14-M315	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part II Date/Time Prepared: 4/28/2021 12:36 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	788,912		
2.00	Net IPF PPS Outlier Payments	74,965		
3.00	Net IPF PPS ECT Payments	0		
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00		
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00		
5.00	New Teaching program adjustment. (see instructions)	0.00		
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00		
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00		
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00		
9.00	Average Daily Census (see instructions)	4.543716		
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.	0.000000		
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0		
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	863,877		
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0		
14.00	Organ acquisition (DO NOT USE THIS LINE)	0		
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0		
16.00	Subtotal (see instructions)	863,877		
17.00	Primary payer payments	0		
18.00	Subtotal (line 16 less line 17).	863,877		
19.00	Deductibles	104,632		
20.00	Subtotal (line 18 minus line 19)	759,245		
21.00	Coinsurance	16,676		
22.00	Subtotal (line 20 minus line 21)	742,569		
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,904		
24.00	Adjusted reimbursable bad debts (see instructions)	23,338		
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	35,904		
26.00	Subtotal (sum of lines 22 and 24)	765,907		
27.00	Direct graduate medical education payments (see instructions)	0		
28.00	Other pass through costs (see instructions)	0		
29.00	Outlier payments reconciliation	0		
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		
30.99	Demonstration payment adjustment amount before sequestration	0		
31.00	Total amount payable to the provider (see instructions)	765,907		
31.01	Sequestration adjustment (see instructions)	8,885		
31.02	Demonstration payment adjustment amount after sequestration	0		
32.00	Interim payments	735,142		
33.00	Tentative settlement (for contractor use only)	0		
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	21,880		
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	74,965		
51.00	Outlier reconciliation adjustment amount (see instructions)	0		
52.00	The rate used to calculate the Time Value of Money	0.00		
53.00	Time Value of Money (see instructions)	0		

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

Provider CCN: 14-1315

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

Worksheet G

Date/Time Prepared:
4/28/2021 12:36 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	15,826,901	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	10,145,816	0	0	0	4.00
5.00	Other receivable	195,426	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,661,000	0	0	0	6.00
7.00	Inventory	1,021,420	0	0	0	7.00
8.00	Prepaid expenses	218,081	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,746,644	0	0	0	11.00
FIXED ASSETS						
12.00	Land	279,691	0	0	0	12.00
13.00	Land improvements	533,487	0	0	0	13.00
14.00	Accumulated depreciation	-436,233	0	0	0	14.00
15.00	Buildings	18,145,535	0	0	0	15.00
16.00	Accumulated depreciation	-7,517,067	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,889,833	0	0	0	23.00
24.00	Accumulated depreciation	-5,551,602	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,343,644	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	5,119,436	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	142,446	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,261,882	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,352,170	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,458,485	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,322,124	0	0	0	38.00
39.00	Payroll taxes payable	35,433	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	414,704	0	0	0	43.00
44.00	Other current liabilities	6,679,328	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,910,074	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	2,044,356	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	117,320	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,161,676	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,071,750	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,280,420				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)	24,280,420	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,352,170	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1315

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

Worksheet G-1

Date/Time Prepared:
4/28/2021 12:36 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		21,450,986		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,829,259				2.00
3.00	Total (sum of line 1 and line 2)		24,280,245		0		3.00
4.00	MISCELLANEOUS	175		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		175		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,280,420		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,280,420		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	MISCELLANEOUS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1315

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/28/2021 12:36 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,761,513		1,761,513	1.00
2.00	SUBPROVIDER - IPF	4,074,626		4,074,626	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	241,898		241,898	5.00
6.00	Swing bed - NF	79,134		79,134	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)	6,157,171		6,157,171	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,157,171		6,157,171	17.00
18.00	Ancillary services	4,645,895	53,599,408	58,245,303	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,983,976	2,983,976	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS PRIVATE OFFICE	748	343,624	344,372	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,803,814	56,927,008	67,730,822	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,881,213		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,881,213		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1315

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

Worksheet G-3

Date/Time Prepared:
4/28/2021 12:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,730,822	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,377,694	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,353,128	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,881,213	4.00
5.00	Net income from service to patients (line 3 minus line 4)	471,915	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	3,073	6.00
7.00	Income from investments	196,357	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	68,773	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	90,685	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	991,555	24.00
24.50	COVID-19 PHE Funding	1,006,901	24.50
25.00	Total other income (sum of lines 6-24)	2,357,344	25.00
26.00	Total (line 5 plus line 25)	2,829,259	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,829,259	29.00

Health Financial Systems		BCC DBA ILLINI COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10	
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS				Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet M-1
				Component CCN: 14-3482		Date/Time Prepared: 4/28/2021 12:36 pm
				RHC I		Cost
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	303,484	0	303,484	0	303,484
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	423,730	0	423,730	0	423,730
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
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	486,030	0	486,030	0	486,030
10.00	Subtotal (sum of lines 1 through 9)	1,213,244	0	1,213,244	0	1,213,244
11.00	Physician Services Under Agreement	0	207,209	207,209	0	207,209
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	128,964	128,964	0	128,964
14.00	Subtotal (sum of lines 11 through 13)	0	336,173	336,173	0	336,173
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	58,671	58,671	-350	58,321
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	58,671	58,671	-350	58,321
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,213,244	394,844	1,608,088	-350	1,607,738
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	29,893	7,438	37,331	0	37,331
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)	29,893	7,438	37,331	0	37,331
FACILITY OVERHEAD						
29.00	Facility Costs	0	54	54	0	54
30.00	Administrative Costs	138,186	30,015	168,201	0	168,201
31.00	Total Facility Overhead (sum of lines 29 and 30)	138,186	30,069	168,255	0	168,255
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,381,323	432,351	1,813,674	-350	1,813,324

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315

Period:

Worksheet M-1

Component CCN: 14-3482

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 12:36 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	303,484	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	423,730	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	486,030	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,213,244	10.00
11.00	Physician Services Under Agreement	39,605	246,814	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	-111,641	17,323	13.00
14.00	Subtotal (sum of lines 11 through 13)	-72,036	264,137	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	58,321	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58,321	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-72,036	1,535,702	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	37,331	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	37,331	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-29	25	29.00
30.00	Administrative Costs	0	168,201	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-29	168,226	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-72,065	1,741,259	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1315

Period:

Worksheet M-2

Component CCN: 14-3482

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/28/2021 12:36 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.56	2,882	4,200	6,552	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	3.03	6,536	2,100	6,363	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.59	9,418		12,915	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	0.82	964		964	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.41	10,382		13,879	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,535,702	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				37,331	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,573,033	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.976268	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				168,226	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,553,614	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,721,840	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,721,840	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,680,977	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,216,679	20.00

Health Financial Systems		BCC DBA ILLINI COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 14-3482		Date/Time Prepared: 4/28/2021 12:36 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)			3,216,679	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			55,874	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,160,805	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,879	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)			13,879	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			227.74	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)		227.74	227.74	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		621	1,883	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		141,427	428,834	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	17	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	3,872	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	3,872	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	574,133	16.00
16.01	Total program charges (see instructions)(from contractor's records)			642,212	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			89,422	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			79,943	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.)			357,344	16.04
16.05	Total program cost (see instructions)		0	437,287	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			47,510	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			101,056	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			437,287	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			20,506	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			457,793	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)			457,793	26.00
26.01	Sequestration adjustment (see instructions)			5,310	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			426,931	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)			25,552	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 12:36 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)		1,213,244	1,213,244	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001013	0.004013	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,229	4,869	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		8,649	11,928	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		9,878	16,797	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,535,702	1,535,702	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,680,977	1,680,977	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.006432	0.010938	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		10,812	18,387	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		20,690	35,184	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		231	915	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		89.57	38.45	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		92	319	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		8,240	12,266	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)			55,874	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)			20,506	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 12:36 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		466,969	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		04/08/2020	40,038	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)		-40,038	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		426,931	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		25,552	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		452,483	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00