

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

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

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

Provider CCN: 14-1318

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

Worksheet S
Parts I-III
Date/Time Prepared:
4/23/2021 1:22 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/23/2021	Time: 1:22 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF HOLY FAMILY MED CTR (14-1318) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	100,568	377,897	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	109,443	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		99,180		0	10.00
200.00	Total	0	210,011	477,077	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-1318		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/23/2021 1:22 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1000 WEST HARLEM AVENUE			PO Box:				1.00		
2.00	City: MONMOUTH			State: IL		Zip Code: 61462		County: WARREN		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		OSF HOLY FAMILY MED CTR	141318	99914	1	05/01/2002	N	O	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		OSF HOLY FAMILY SWING BEDS	142318	99914		05/01/2002	N	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		OSF HOLY FAMILY CLINICS	143461	99914		02/05/2003	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2019	09/30/2020		20.00
21.00	Type of Control (see instructions)						1			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0	N			23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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

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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	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.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/23/2021 1:22 pm	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N					111.00
						1.00	
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					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:	203,097		0	21,064		118.01
						1.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N					122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/23/2021 1:22 pm	
		1.00		2.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149006		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:				142.00	
143.00	City: PEORIA	State: IL		Zip Code: 61603		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/23/2021 1:22 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1318		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part II Date/Time Prepared: 4/23/2021 1:22 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/14/2020	Y	12/14/2020		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/23/2021 1:22 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.231.5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1318

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,418	11,389.39	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,418	11,389.39	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		23	8,418	11,389.39	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		23				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	329	9	479		1.00
2.00	HMO and other (see instructions)	60	21			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	358	11	479		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	32		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	687	20	990		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)	687	20	990	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	5,289	6,761	24,519	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		17	147		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	116	3	174	1.00
2.00 HMO and other (see instructions)			23	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	116	3	174	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1318 Component CCN: 14-3461		Period: From 10/01/2019 To 09/30/2020		Worksheet S-8 Date/Time Prepared: 4/23/2021 1:22 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1000 W. HARLEM			1.00		
			City		State		ZIP Code		
			1.00		2.00		3.00		
2.00	City, State, ZIP Code, County			MONMOUTH		ILLINOIS		61462	
							1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:00		18:00		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							14.00	
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			WARREN				2.00	
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC			18:00		07:00		18:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1318 Component CCN: 14-3461		Period: From 10/01/2019 To 09/30/2020		Worksheet S-8 Date/Time Prepared: 4/23/2021 1:22 pm	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)								
	CLINIC	07:00	18:00	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1318	Period: From 10/01/2019 To 09/30/2020	Worksheet S-10 Date/Time Prepared: 4/23/2021 1:22 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.370757	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,208,028	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		11,458,678	6.00
7.00	Medicaid cost (line 1 times line 6)		4,248,385	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)		1,040,357	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)		1,040,357	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,403,716	375,220	1,778,936
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	520,438	375,220	895,658
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	520,438	375,220	895,658
				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)		1,622,136	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		137,256	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		211,164	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,410,972	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		597,036	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,492,694	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,533,051	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1318

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

Worksheet A

Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		658,959	658,959	328,643	987,602 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		296,149	296,149	402,548	698,697 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,900	428,213	433,113	2,444,091	2,877,204 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	991,705	5,811,544	6,803,249	-926,239	5,877,010 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	506,965	506,965	-259,240	247,725 6.00
7.00	00700	OPERATION OF PLANT	221,721	866,138	1,087,859	-223,924	863,935 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	90,879	90,879 8.00
9.00	00900	HOUSEKEEPING	345,879	247,452	593,331	-211,724	381,607 9.00
10.00	01000	DIETARY	257,762	189,502	447,264	-98,332	348,932 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	54,884	13,860	68,744	82,751	151,495 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59,199	19,549	78,748	-13,323	65,425 16.00
17.00	01700	SOCIAL SERVICE	14,788	3,034	17,822	245,862	263,684 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	825,751	309,897	1,135,648	-163,407	972,241 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	396,394	263,934	660,328	-237,890	422,438 50.00
53.00	05300	ANESTHESIOLOGY	194,530	63,143	257,673	-26,093	231,580 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	548,719	353,408	902,127	-11,698	890,429 54.00
56.00	05600	RADIOISOTOPE	25,991	31,704	57,695	-5,050	52,645 56.00
57.00	05700	CT SCAN	0	43,642	43,642	-42,834	808 57.00
58.00	05800	MRI	0	203,036	203,036	-2,860	200,176 58.00
60.00	06000	LABORATORY	497,362	640,883	1,138,245	-153,112	985,133 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	146,732	49,618	196,350	-48,010	148,340 65.00
66.00	06600	PHYSICAL THERAPY	294,521	66,401	360,922	-42,179	318,743 66.00
67.00	06700	OCCUPATIONAL THERAPY	101,357	18,934	120,291	-11,525	108,766 67.00
68.00	06800	SPEECH PATHOLOGY	11,767	1,168	12,935	-329	12,606 68.00
69.00	06900	ELECTROCARDIOLOGY	145,108	48,314	193,422	-44,584	148,838 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-25,875	-25,875	220,524	194,649 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,619	11,619 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	206,414	1,523,960	1,730,374	-17,643	1,712,731 73.00
76.00	03950	DIABETIC SERVICES	57,093	21,298	78,391	-18,453	59,938 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,108,743	1,866,565	4,975,308	-989,815	3,985,493 88.00
91.00	09100	EMERGENCY	975,005	3,060,450	4,035,455	-278,653	3,756,802 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,486,325	17,581,845	27,068,170	0	27,068,170 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	9,486,325	17,581,845	27,068,170	0	27,068,170 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1318

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

Worksheet A

Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	362,875	1,350,477	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	146,342	845,039	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	371,482	3,248,686	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,053,614	4,823,396	5.00
6.00	00600	MAINTENANCE & REPAIRS	-3,562	244,163	6.00
7.00	00700	OPERATION OF PLANT	0	863,935	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	90,879	8.00
9.00	00900	HOUSEKEEPING	0	381,607	9.00
10.00	01000	DIETARY	0	348,932	10.00
11.00	01100	CAFETERIA	-35,459	-35,459	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	222,881	374,376	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,933	61,492	16.00
17.00	01700	SOCIAL SERVICE	-110,564	153,120	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-131,138	841,103	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	422,438	50.00
53.00	05300	ANESTHESIOLOGY	-194,530	37,050	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,431	895,860	54.00
56.00	05600	RADIOISOTOPE	0	52,645	56.00
57.00	05700	CT SCAN	0	808	57.00
58.00	05800	MRI	0	200,176	58.00
60.00	06000	LABORATORY	-391	984,742	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	148,340	65.00
66.00	06600	PHYSICAL THERAPY	0	318,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,766	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,606	68.00
69.00	06900	ELECTROCARDIOLOGY	0	148,838	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	194,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-618,108	1,094,623	73.00
76.00	03950	DIABETIC SERVICES	0	59,938	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-40,592	3,944,901	88.00
91.00	09100	EMERGENCY	-2,385,308	1,371,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,468,188	23,599,982	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,468,188	23,599,982	200.00

RECLASSIFICATIONS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet A-6
Date/Time Prepared:
4/23/2021 1:22 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MAINTENANCE COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	232,099		1.00
2.00	LABORATORY	60.00	0	27,141		2.00
	0		0	259,240		
	B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	226,481		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,538		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	232,019		
	F - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	20,400		1.00
	0		0	20,400		
	G - EMPLOYEE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,248,674		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	0		0	2,248,674		
	I - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	314,270		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	396,521		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
20.00		0.00	0	0		20.00
	0		0	710,791		
	J - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	8,559	82,320		1.00
	0		8,559	82,320		

RECLASSIFICATIONS

Provider CCN: 14-1318

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

Worksheet A-6

Date/Time Prepared:
4/23/2021 1:22 pm

Increases					
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,619	1.00
	0		0	11,619	
M - MINISTRY ALLOCATION RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	195,417	1.00
2.00	OPERATION OF PLANT	7.00	0	62,958	2.00
3.00	SOCIAL SERVICE	17.00	0	246,380	3.00
4.00	PHYSICAL THERAPY	66.00	0	20,640	4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	6,879	5.00
6.00	SPEECH PATHOLOGY	68.00	0	740	6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	37,237	7.00
	0		0	570,251	
N - PHYSICIAN NON-RHC VISITS					
1.00	ADULTS & PEDIATRICS	30.00	71,631	0	1.00
	TOTALS		71,631	0	
O - VP CHIEF NURSING OFFICER					
1.00	NURSING ADMINISTRATION	13.00	96,611	0	1.00
	TOTALS		96,611	0	
500.00	Grand Total: Increases		176,801	4,135,314	500.00

RECLASSIFICATIONS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet A-6
Date/Time Prepared:
4/23/2021 1:22 pm

	Decreases						4/20/2021	FILE	pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.				
	6.00	7.00	8.00	9.00	10.00				
	A - MAINTENANCE COSTS								
1.00	MAINTENANCE & REPAIRS	6.00	0	259,240	0			1.00	
2.00		0.00	0	0	0			2.00	
	0		0	259,240					
	B - MEDICAL SUPPLIES								
1.00	ADULTS & PEDIATRICS	30.00	0	26,809	0			1.00	
2.00	OPERATING ROOM	50.00	0	53,280	0			2.00	
3.00	ANESTHESIOLOGY	53.00	0	2,250	0			3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,573	0			4.00	
5.00	RADIOISOTOPE	56.00	0	250	0			5.00	
6.00	CT SCAN	57.00	0	24,312	0			6.00	
7.00	MRI	58.00	0	2,860	0			7.00	
8.00	LABORATORY	60.00	0	26,036	0			8.00	
9.00	RESPIRATORY THERAPY	65.00	0	3,577	0			9.00	
10.00	PHYSICAL THERAPY	66.00	0	3,579	0			10.00	
11.00	OCCUPATIONAL THERAPY	67.00	0	715	0			11.00	
12.00	ELECTROCARDIOLOGY	69.00	0	1,353	0			12.00	
13.00	DIABETIC SERVICES	76.00	0	2,106	0			13.00	
14.00	EMERGENCY	91.00	0	63,319	0			14.00	
	0		0	232,019					
	F - PROPERTY INSURANCE								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,400	12			1.00	
	0		0	20,400					
	G - EMPLOYEE BENEFIT RECLASS								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	221,243	0			1.00	
2.00	OPERATION OF PLANT	7.00	0	78,148	0			2.00	
3.00	HOUSEKEEPING	9.00	0	119,101	0			3.00	
4.00	DIETARY	10.00	0	86,017	0			4.00	
5.00	NURSING ADMINISTRATION	13.00	0	13,860	0			5.00	
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	13,323	0			6.00	
7.00	SOCIAL SERVICE	17.00	0	518	0			7.00	
8.00	ADULTS & PEDIATRICS	30.00	0	171,703	0			8.00	
9.00	OPERATING ROOM	50.00	0	85,204	0			9.00	
10.00	ANESTHESIOLOGY	53.00	0	20,916	0			10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	132,654	0			11.00	
12.00	RADIOISOTOPE	56.00	0	1,477	0			12.00	
13.00	LABORATORY	60.00	0	134,280	0			13.00	
14.00	RESPIRATORY THERAPY	65.00	0	42,438	0			14.00	
15.00	PHYSICAL THERAPY	66.00	0	56,827	0			15.00	
16.00	OCCUPATIONAL THERAPY	67.00	0	17,689	0			16.00	
17.00	SPEECH PATHOLOGY	68.00	0	1,069	0			17.00	
18.00	ELECTROCARDIOLOGY	69.00	0	33,241	0			18.00	
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	42,001	0			19.00	
20.00	DIABETIC SERVICES	76.00	0	16,347	0			20.00	
21.00	RURAL HEALTH CLINIC	88.00	0	777,898	0			21.00	
22.00	EMERGENCY	91.00	0	182,720	0			22.00	
	0		0	2,248,674					
	I - DEPRECIATION RECLASS								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,734	9			1.00	
2.00	OPERATION OF PLANT	7.00	0	208,734	9			2.00	
3.00	HOUSEKEEPING	9.00	0	1,744	0			3.00	
4.00	DIETARY	10.00	0	12,315	0			4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	36,526	0			5.00	
6.00	OPERATING ROOM	50.00	0	87,787	0			6.00	
7.00	ANESTHESIOLOGY	53.00	0	2,927	0			7.00	
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	89,570	0			8.00	
9.00	RADIOISOTOPE	56.00	0	3,323	0			9.00	
10.00	CT SCAN	57.00	0	18,522	0			10.00	
11.00	LABORATORY	60.00	0	19,937	0			11.00	
12.00	RESPIRATORY THERAPY	65.00	0	1,995	0			12.00	
13.00	PHYSICAL THERAPY	66.00	0	2,413	0			13.00	
14.00	ELECTROCARDIOLOGY	69.00	0	9,990	0			14.00	
15.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,957	0			15.00	
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	18,417	0			16.00	
17.00	RURAL HEALTH CLINIC	88.00	0	140,286	0			17.00	
18.00	EMERGENCY	91.00	0	32,614	0			18.00	
20.00	EMERGENCY		0		0			20.00	
	0		0	710,791					
	J - LAUNDRY RECLASS								
1.00	HOUSEKEEPING	9.00	8,559	82,320	0			1.00	
	0		8,559	82,320					

RECLASSIFICATIONS

Provider CCN: 14-1318

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

Worksheet A-6

Date/Time Prepared:
4/23/2021 1:22 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	K - IMPLANTABLE DEVICES						1.00
	OPERATING ROOM	50.00	0	11,619	0		
	0		0	11,619			
	M - MINISTRY ALLOCATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	570,251	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		0	570,251			
	N - PHYSICIAN NON-RHC VISITS						
1.00	RURAL HEALTH CLINIC	88.00	71,631	0	0		1.00
	TOTALS		71,631	0			
	O - VP CHIEF NURSING OFFICER						
1.00	ADMINISTRATIVE & GENERAL	5.00	96,611	0	0		1.00
	TOTALS		96,611	0			
500.00	Grand Total: Decreases		176,801	4,135,314			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	325,000	0	0	0	0	1.00	
2.00	Land Improvements	369,733	0	0	0	0	2.00	
3.00	Buildings and Fixtures	19,220,858	1,395,823	0	1,395,823	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	8,259,330	677,271	0	677,271	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	28,174,921	2,073,094	0	2,073,094	0	8.00	
9.00	Reconciling Items	256,663	164,058	0	164,058	0	9.00	
10.00	Total (line 8 minus line 9)	27,918,258	1,909,036	0	1,909,036	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	325,000	0				1.00	
2.00	Land Improvements	369,733	0				2.00	
3.00	Buildings and Fixtures	20,616,681	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,936,601	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	30,248,015	0				8.00	
9.00	Reconciling Items	420,721	0				9.00	
10.00	Total (line 8 minus line 9)	29,827,294	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	658,959	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	296,149	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	955,108	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	658,959				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	296,149				2.00
3.00	Total (sum of lines 1-2)	0	955,108				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,311,414	0	21,311,414	0.704556	14,373	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,936,601	0	8,936,601	0.295444	6,027	2.00
3.00	Total (sum of lines 1-2)	30,248,015	0	30,248,015	1.000000	20,400	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	14,373	1,336,104	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,027	839,012	0	2.00
3.00	Total (sum of lines 1-2)	0	0	20,400	2,175,116	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	14,373	0	0	1,350,477	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,027	0	0	845,039	2.00
3.00	Total (sum of lines 1-2)	0	20,400	0	0	2,195,516	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1318

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

Worksheet A-8

Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-265	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-8,434	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,722,137			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	45,176			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-35,459	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,933	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-9,296	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	287,767	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	121,388	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1318

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

Worksheet A-8

Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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	ADVERTISING EXPENSE	A	-1,440	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.02	LOBBYING	A	-11,619	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.05	LASALA - ER BENEFITS	A	-1,512	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.05
35.00	WIECHERT - ER BENEFITS	A	-5,256	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
37.00	PROVIDER TAX IDPA	A	-853,536	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	MISC. INCOME	B	-343	ADMINISTRATIVE & GENERAL	5.00	0	37.01
38.02	340B EXPENSE	A	-618,108	DRUGS CHARGED TO PATIENTS	73.00	0	38.02
39.00	CRNA BENEFITS	A	-30,465	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
39.01	UNEMPLOYMENT COMP	A	406,244	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.01
39.02	HOSPITALIST & IP PALLIATIVE CARE	A	11,161	ADULTS & PEDIATRICS	30.00	0	39.02
39.03	DR. LEONARD RHC SALARY EXPENSE	A	12,034	RURAL HEALTH CLINIC	88.00	0	39.03
39.04	DR. LEONARD RHC BENEFIT EXPENSE	A	1,725	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.04
39.05	NON-RHC VISITS PA SALARY EXPENSE	A	-28,551	RURAL HEALTH CLINIC	88.00	0	39.05
39.06	NON-RHC VISIT PA & PHYSICIAN BENEFIT	A	-25,066	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.06
39.07	DEFINED BENEFIT PENSION	A	25,812	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.07
39.08	MEDICAL DIRECTOR FEE	A	-24,075	RURAL HEALTH CLINIC	88.00	0	39.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-3,468,188				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1318

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

Worksheet A-8-1

Date/Time Prepared:
4/23/2021 1:22 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	75,108	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	290,717	265,763	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO POOLED - ADMIN & GENERAL	2,333,306	2,854,086	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	195,417	195,417	3.01
3.02	6.00	MAINTENANCE & REPAIRS	MINISTRY ALLOCATION	159,464	159,464	3.02
3.03	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	62,958	62,958	3.03
3.04	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	20,640	20,640	3.04
3.05	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	6,879	6,879	3.05
3.06	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	740	740	3.06
3.07	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	87,663	87,663	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	109,614	149,412	3.08
3.09	60.00	LABORATORY	MINISTRY ALLOCATION	17,493	17,493	3.09
4.00	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	222,881	0	4.00
4.01	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	135,816	246,380	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO FUNCTIONAL - ADMIN & GEN	1,227,055	875,115	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	SFI ETS	49,588	0	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	SFI EQUIPMENT RENTAL	1,787	2,808	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	SFI CVO	37,988	37,829	4.05
4.06	6.00	MAINTENANCE & REPAIRS	SFI HEALTHCARE TECHNOLOGY SV	84,677	88,239	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	SFI HEALTHCARE TECHNOLOGY SV	79,339	82,677	4.07
4.08	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	9,289	9,680	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,208,419	5,163,243	5.00

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

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

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

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

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

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

Provider CCN: 14-1318

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

Worksheet A-8-1

Date/Time Prepared:
4/23/2021 1:22 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	75,108	9		1.00
2.00	24,954	9		2.00
3.00	-520,780	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	-39,798	0		3.08
3.09	0	0		3.09
4.00	222,881	0		4.00
4.01	-110,564	0		4.01
4.02	351,940	0		4.02
4.03	49,588	0		4.03
4.04	-1,021	0		4.04
4.05	159	0		4.05
4.06	-3,562	0		4.06
4.07	-3,338	0		4.07
4.08	-391	0		4.08
5.00	45,176			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1318

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

Worksheet A-8-2

Date/Time Prepared:
4/23/2021 1:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	142,299	142,299	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	229,950	194,530	35,420	0	0	2.00
3.00	60.00	LABORATORY	14,400	0	14,400	0	0	3.00
4.00	91.00	EMERGENCY	2,679,871	2,364,450	315,421	0	0	4.00
5.00	91.00	EMERGENCY	25,404	5,256	20,148	0	0	5.00
6.00	91.00	EMERGENCY	16,193	15,602	591	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,108,117	2,722,137	385,980		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	142,299		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	194,530		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	2,364,450		4.00
5.00	91.00	EMERGENCY	0	0	0	5,256		5.00
6.00	91.00	EMERGENCY	0	0	0	15,602		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,722,137		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:22 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	1,350,477	1,350,477			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	845,039		845,039		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,248,686	0	0	3,248,686	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,823,396	235,375	147,284	316,836	5.00
6.00	00600	MAINTENANCE & REPAIRS	244,163	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	863,935	152,963	95,714	78,482	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,879	0	0	3,030	8.00
9.00	00900	HOUSEKEEPING	381,607	16,141	10,100	119,401	9.00
10.00	01000	DIETARY	348,932	91,417	57,203	91,240	10.00
11.00	01100	CAFETERIA	-35,459	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	374,376	0	0	53,625	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,492	24,039	15,042	20,955	16.00
17.00	01700	SOCIAL SERVICE	153,120	0	0	5,234	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	841,103	142,419	89,116	292,290	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	422,438	78,781	49,296	140,311	50.00
53.00	05300	ANESTHESIOLOGY	37,050	3,201	2,003	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	895,860	69,526	43,505	194,230	54.00
56.00	05600	RADIOISOTOPE	52,645	0	0	9,200	56.00
57.00	05700	CT SCAN	808	0	0	0	57.00
58.00	05800	MRI	200,176	0	0	0	58.00
60.00	06000	LABORATORY	984,742	26,325	16,472	176,051	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	148,340	0	0	51,939	65.00
66.00	06600	PHYSICAL THERAPY	318,743	61,531	38,502	104,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,766	3,893	2,436	35,877	67.00
68.00	06800	SPEECH PATHOLOGY	12,606	485	303	4,165	68.00
69.00	06900	ELECTROCARDIOLOGY	148,838	23,014	14,400	51,364	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	194,649	48,882	30,587	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,619	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,094,623	15,393	9,632	73,064	73.00
76.00	03950	DIABETIC SERVICES	59,938	17,028	10,655	20,209	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,944,901	217,043	135,811	1,069,194	88.00
91.00	09100	EMERGENCY	1,371,494	84,808	53,067	337,738	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,599,982	1,312,264	821,128	3,248,686	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	38,213	23,911	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,599,982	1,350,477	845,039	3,248,686	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:22 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	5,522,891					5.00
6.00	00600	MAINTENANCE & REPAIRS	74,450	318,613				6.00
7.00	00700	OPERATION OF PLANT	363,190	45,256	1,599,540			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,635	0	0	122,544		8.00
9.00	00900	HOUSEKEEPING	160,769	4,776	26,835	0	719,629	9.00
10.00	01000	DIETARY	179,535	27,047	151,980	0	69,542	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	130,506	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,056	7,112	39,964	0	18,287	16.00
17.00	01700	SOCIAL SERVICE	48,285	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	416,195	42,137	236,768	40,593	108,339	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	210,647	23,309	130,972	10,154	59,930	50.00
53.00	05300	ANESTHESIOLOGY	12,884	947	5,321	0	2,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	366,857	20,570	115,586	21,729	52,889	54.00
56.00	05600	RADIOISOTOPE	18,858	0	0	0	0	56.00
57.00	05700	CT SCAN	246	0	0	0	0	57.00
58.00	05800	MRI	61,038	0	0	0	0	58.00
60.00	06000	LABORATORY	367,000	7,789	43,765	360	20,026	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	61,069	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	159,482	18,205	102,295	10,583	46,807	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,035	1,152	6,473	0	2,962	67.00
68.00	06800	SPEECH PATHOLOGY	5,354	143	806	0	369	68.00
69.00	06900	ELECTROCARDIOLOGY	72,454	6,809	38,260	1,957	17,507	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,584	14,462	81,265	0	37,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,543	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	363,683	4,554	25,591	0	11,710	73.00
76.00	03950	DIABETIC SERVICES	32,880	5,038	28,309	0	12,953	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,636,491	64,215	360,830	1,490	165,105	88.00
91.00	09100	EMERGENCY	563,222	25,092	140,992	33,733	64,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,503,948	318,613	1,536,012	120,599	690,560	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	18,943	0	63,528	1,945	29,069	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,522,891	318,613	1,599,540	122,544	719,629	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,016,896					10.00
11.00	01100	CAFETERIA	761,800	726,341				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	10,661	0	569,168		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,834	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,611	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	211,003	122,089	0	263,344	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,233	47,976	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,480	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85,376	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	3,009	0	0	0	56.00
57.00	05700	CT SCAN	0	172	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	84,688	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	25,020	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,128	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,566	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	774	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,440	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,422	0	35,453	0	73.00
76.00	03950	DIABETIC SERVICES	0	7,480	0	16,139	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	110,739	0	0	0	88.00
91.00	09100	EMERGENCY	3,860	117,876	0	254,232	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,016,896	726,341	0	569,168	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,016,896	726,341	0	569,168	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	253,781				16.00
17.00	01700	SOCIAL SERVICE	0	0	210,250			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,555	210,250	3,025,201	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	10,783	0	1,224,830	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,081	0	74,402	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,090	0	1,888,218	0	54.00
56.00	05600	RADIOISOTOPE	0	2,404	0	86,116	0	56.00
57.00	05700	CT SCAN	0	32,149	0	33,375	0	57.00
58.00	05800	MRI	0	8,790	0	270,004	0	58.00
60.00	06000	LABORATORY	0	51,448	0	1,778,666	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,925	0	288,293	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,162	0	892,689	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,131	0	217,291	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	354	0	25,359	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,641	0	407,684	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	962	0	491,576	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	361	0	15,523	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,516	0	1,678,641	0	73.00
76.00	03950	DIABETIC SERVICES	0	135	0	210,764	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	25,357	0	7,731,176	0	88.00
91.00	09100	EMERGENCY	0	33,937	0	3,084,565	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	253,781	210,250	23,424,373	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	175,609	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	253,781	210,250	23,599,982	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	398,916	235,375	147,284	781,575	0 5.00
6.00	00600	MAINTENANCE & REPAIRS	1,498	0	0	1,498	0 6.00
7.00	00700	OPERATION OF PLANT	0	152,963	95,714	248,677	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	0	16,141	10,100	26,241	0 9.00
10.00	01000	DIETARY	0	91,417	57,203	148,620	0 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,039	15,042	39,081	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	142,419	89,116	231,535	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	78,781	49,296	128,077	0 50.00
53.00	05300	ANESTHESIOLOGY	0	3,201	2,003	5,204	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,882	69,526	43,505	188,913	0 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	8,523	26,325	16,472	51,320	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	340	61,531	38,502	100,373	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,893	2,436	6,329	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	485	303	788	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,014	14,400	37,414	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	48,882	30,587	79,469	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,393	9,632	25,025	0 73.00
76.00	03950	DIABETIC SERVICES	0	17,028	10,655	27,683	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	663	217,043	135,811	353,517	0 88.00
91.00	09100	EMERGENCY	0	84,808	53,067	137,875	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	485,822	1,312,264	821,128	2,619,214	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	38,213	23,911	62,124	0 192.00
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers				0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	485,822	1,350,477	845,039	2,681,338	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	781,575					5.00
6.00	00600	MAINTENANCE & REPAIRS	10,536	12,034				6.00
7.00	00700	OPERATION OF PLANT	51,397	1,709	301,783			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,052	0	0	4,052		8.00
9.00	00900	HOUSEKEEPING	22,751	180	5,063	0	54,235	9.00
10.00	01000	DIETARY	25,407	1,022	28,674	0	5,241	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	18,469	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,244	269	7,540	0	1,378	16.00
17.00	01700	SOCIAL SERVICE	6,833	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	58,898	1,591	44,671	1,343	8,165	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,810	880	24,710	336	4,517	50.00
53.00	05300	ANESTHESIOLOGY	1,823	36	1,004	0	183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,916	777	21,807	718	3,986	54.00
56.00	05600	RADIOISOTOPE	2,669	0	0	0	0	56.00
57.00	05700	CT SCAN	35	0	0	0	0	57.00
58.00	05800	MRI	8,638	0	0	0	0	58.00
60.00	06000	LABORATORY	51,936	294	8,257	12	1,509	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,642	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	22,569	688	19,300	350	3,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,515	44	1,221	0	223	67.00
68.00	06800	SPEECH PATHOLOGY	758	5	152	0	28	68.00
69.00	06900	ELECTROCARDIOLOGY	10,253	257	7,218	65	1,319	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,828	546	15,332	0	2,802	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	501	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,467	172	4,828	0	883	73.00
76.00	03950	DIABETIC SERVICES	4,653	190	5,341	0	976	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	231,589	2,426	68,078	49	12,444	88.00
91.00	09100	EMERGENCY	79,705	948	26,601	1,115	4,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	778,894	12,034	289,797	3,988	52,044	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,681	0	11,986	64	2,191	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	781,575	12,034	301,783	4,052	54,235	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	208,964					10.00
11.00	01100	CAFETERIA	156,544	149,257				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,191	0	20,660		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,131	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	742	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,359	25,088	0	9,559	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,268	9,859	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,537	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,544	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	618	0	0	0	56.00
57.00	05700	CT SCAN	0	35	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	17,403	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,141	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,753	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,555	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	159	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,611	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,375	0	1,287	0	73.00
76.00	03950	DIABETIC SERVICES	0	1,537	0	586	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	22,756	0	0	0	88.00
91.00	09100	EMERGENCY	793	24,222	0	9,228	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	208,964	149,257	0	20,660	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	7,287	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	208,964	156,544	0	20,660	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	59,643				16.00
17.00	01700	SOCIAL SERVICE	0	0	7,575			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,245	7,575	434,029	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,534	0	208,991	0	50.00
53.00	05300	ANESTHESIOLOGY	0	724	0	10,511	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,191	0	290,852	0	54.00
56.00	05600	RADIOISOTOPE	0	565	0	3,852	0	56.00
57.00	05700	CT SCAN	0	7,555	0	7,625	0	57.00
58.00	05800	MRI	0	2,066	0	10,704	0	58.00
60.00	06000	LABORATORY	0	12,095	0	142,826	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	452	0	14,235	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,153	0	153,714	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	501	0	16,388	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	83	0	1,973	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,501	0	63,638	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	226	0	110,203	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	85	0	586	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,701	0	93,738	0	73.00
76.00	03950	DIABETIC SERVICES	0	32	0	40,998	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,959	0	696,818	0	88.00
91.00	09100	EMERGENCY	0	7,975	0	293,324	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	59,643	7,575	2,595,005	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	79,046	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	7,287	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	59,643	7,575	2,681,338	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1

Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,470					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		97,470				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,177,889			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,988	16,988	895,094	-5,522,891	18,112,550	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	244,163	6.00
7.00	00700	OPERATION OF PLANT	11,040	11,040	221,721	0	1,191,094	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8,559	0	93,909	8.00
9.00	00900	HOUSEKEEPING	1,165	1,165	337,320	0	527,249	9.00
10.00	01000	DIETARY	6,598	6,598	257,762	0	588,792	10.00
11.00	01100	CAFETERIA	0	0	0	35,459	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	151,495	0	428,001	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,735	1,735	59,199	0	121,528	16.00
17.00	01700	SOCIAL SERVICE	0	0	14,788	0	158,354	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,279	10,279	825,751	0	1,364,928	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,686	5,686	396,394	0	690,826	50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	0	42,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	548,719	0	1,203,121	54.00
56.00	05600	RADIOISOTOPE	0	0	25,991	0	61,845	56.00
57.00	05700	CT SCAN	0	0	0	0	808	57.00
58.00	05800	MRI	0	0	0	0	200,176	58.00
60.00	06000	LABORATORY	1,900	1,900	497,362	0	1,203,590	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	146,732	0	200,279	65.00
66.00	06600	PHYSICAL THERAPY	4,441	4,441	294,521	0	523,027	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	101,357	0	150,972	67.00
68.00	06800	SPEECH PATHOLOGY	35	35	11,767	0	17,559	68.00
69.00	06900	ELECTROCARDIOLOGY	1,661	1,661	145,108	0	237,616	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,528	3,528	0	0	274,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	206,414	0	1,192,712	73.00
76.00	03950	DIABETIC SERVICES	1,229	1,229	57,093	0	107,830	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,665	15,665	3,020,595	0	5,366,949	88.00
91.00	09100	EMERGENCY	6,121	6,121	954,147	0	1,847,107	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,712	94,712	9,177,889	-5,487,432	18,050,426	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,758	2,758	0	0	62,124	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,350,477	845,039	3,248,686		5,522,891	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.855309	8.669734	0.353969		0.304921	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		781,575	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.043151	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1

Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	77,724				6.00
7.00	00700	OPERATION OF PLANT	11,040	69,442			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	77,326		8.00
9.00	00900	HOUSEKEEPING	1,165	1,165	0	68,277	9.00
10.00	01000	DIETARY	6,598	6,598	0	6,598	27,398 10.00
11.00	01100	CAFETERIA	0	0	0	0	20,525 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,735	1,735	0	1,735	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,279	10,279	25,615	10,279	5,685 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,686	5,686	6,407	5,686	1,084 50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	231	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	13,711	5,018	0 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	1,900	1,900	227	1,900	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	4,441	4,441	6,678	4,441	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	0	281	0 67.00
68.00	06800	SPEECH PATHOLOGY	35	35	0	35	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,661	1,661	1,235	1,661	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,528	3,528	0	3,528	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	0	1,111	0 73.00
76.00	03950	DIABETIC SERVICES	1,229	1,229	0	1,229	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	15,665	15,665	940	15,665	0 88.00
91.00	09100	EMERGENCY	6,121	6,121	21,286	6,121	104 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,724	66,684	76,099	65,519	27,398 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,758	1,227	2,758	0 192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	318,613	1,599,540	122,544	719,629	1,016,896 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.099287	23.034187	1.584771	10.539845	37.115702 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,034	301,783	4,052	54,235	208,964 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.154830	4.345828	0.052402	0.794338	7.626980 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1

Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,448					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	124	0	63,832			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	347	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	42	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,420	0	29,534	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	558	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	87	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	993	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	35	0	0	0	0	56.00
57.00	05700	CT SCAN	2	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	985	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	291	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	269	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	88	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	261	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191	0	3,976	0	0	73.00
76.00	03950	DIABETIC SERVICES	87	0	1,810	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,288	0	0	0	0	88.00
91.00	09100	EMERGENCY	1,371	0	28,512	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,448	0	63,832	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	726,341	0	569,168	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	85.977865	0.000000	8.916656	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	156,544	0	20,660	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.667732	0.000000	0.323662	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

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

Worksheet B-1

Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,179,894	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,378,692	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,684,336	50.00
53.00	05300	ANESTHESIOLOGY	767,032	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,499,029	54.00
56.00	05600	RADIOISOTOPE	598,333	56.00
57.00	05700	CT SCAN	8,003,294	57.00
58.00	05800	MRI	2,188,175	58.00
60.00	06000	LABORATORY	12,810,466	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	479,206	65.00
66.00	06600	PHYSICAL THERAPY	2,280,742	66.00
67.00	06700	OCCUPATIONAL THERAPY	530,584	67.00
68.00	06800	SPEECH PATHOLOGY	88,051	68.00
69.00	06900	ELECTROCARDIOLOGY	2,649,051	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	239,524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,927	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,098,947	73.00
76.00	03950	DIABETIC SERVICES	33,707	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	6,312,433	88.00
91.00	09100	EMERGENCY	8,448,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,179,894	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	253,781	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004017	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,643	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000944	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,025,201		3,025,201	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,224,830		1,224,830	0
53.00	05300	ANESTHESIOLOGY	74,402		74,402	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,888,218		1,888,218	0
56.00	05600	RADIOISOTOPE	86,116		86,116	0
57.00	05700	CT SCAN	33,375		33,375	0
58.00	05800	MRI	270,004		270,004	0
60.00	06000	LABORATORY	1,778,666		1,778,666	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	288,293	0	288,293	0
66.00	06600	PHYSICAL THERAPY	892,689	0	892,689	0
67.00	06700	OCCUPATIONAL THERAPY	217,291	0	217,291	0
68.00	06800	SPEECH PATHOLOGY	25,359	0	25,359	0
69.00	06900	ELECTROCARDIOLOGY	407,684		407,684	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	491,576		491,576	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,523		15,523	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,678,641		1,678,641	0
76.00	03950	DIABETIC SERVICES	210,764		210,764	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,731,176		7,731,176	0
91.00	09100	EMERGENCY	3,084,565		3,084,565	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	401,770		401,770	0
200.00		Subtotal (see instructions)	23,826,143	0	23,826,143	0
201.00		Less Observation Beds	401,770		401,770	0
202.00		Total (see instructions)	23,424,373	0	23,424,373	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,037,872		2,037,872		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	101,294	2,583,042	2,684,336	0.456288	0.000000
53.00	05300	ANESTHESIOLOGY	29,246	737,786	767,032	0.097000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,451	5,426,578	5,499,029	0.343373	0.000000
56.00	05600	RADIOISOTOPE	5,481	592,852	598,333	0.143927	0.000000
57.00	05700	CT SCAN	130,404	7,872,890	8,003,294	0.004170	0.000000
58.00	05800	MRI	54,045	2,134,130	2,188,175	0.123392	0.000000
60.00	06000	LABORATORY	650,369	12,160,097	12,810,466	0.138845	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	318,744	160,462	479,206	0.601606	0.000000
66.00	06600	PHYSICAL THERAPY	232,261	2,048,481	2,280,742	0.391403	0.000000
67.00	06700	OCCUPATIONAL THERAPY	62,967	467,617	530,584	0.409532	0.000000
68.00	06800	SPEECH PATHOLOGY	16,201	71,850	88,051	0.288004	0.000000
69.00	06900	ELECTROCARDIOLOGY	67,730	2,581,321	2,649,051	0.153898	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,207	233,317	239,524	2.052304	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89,927	89,927	0.172618	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,047,800	6,051,147	7,098,947	0.236463	0.000000
76.00	03950	DIABETIC SERVICES	1,926	31,781	33,707	6.252826	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,312,433	6,312,433		88.00
91.00	09100	EMERGENCY	134,229	8,314,136	8,448,365	0.365108	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	45,339	295,481	340,820	1.178833	0.000000
200.00		Subtotal (see instructions)	5,014,566	58,165,328	63,179,894		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,014,566	58,165,328	63,179,894		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

			Title XIX		Hospital		PPS	
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	3,025,201		3,025,201	0	3,025,201	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,224,830		1,224,830	0	1,224,830	50.00
53.00	05300	ANESTHESIOLOGY	74,402		74,402	0	74,402	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,888,218		1,888,218	0	1,888,218	54.00
56.00	05600	RADIOISOTOPE	86,116		86,116	0	86,116	56.00
57.00	05700	CT SCAN	33,375		33,375	0	33,375	57.00
58.00	05800	MRI	270,004		270,004	0	270,004	58.00
60.00	06000	LABORATORY	1,778,666		1,778,666	0	1,778,666	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	288,293	0	288,293	0	288,293	65.00
66.00	06600	PHYSICAL THERAPY	892,689	0	892,689	0	892,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,291	0	217,291	0	217,291	67.00
68.00	06800	SPEECH PATHOLOGY	25,359	0	25,359	0	25,359	68.00
69.00	06900	ELECTROCARDIOLOGY	407,684		407,684	0	407,684	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	491,576		491,576	0	491,576	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,523		15,523	0	15,523	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,678,641		1,678,641	0	1,678,641	73.00
76.00	03950	DIABETIC SERVICES	210,764		210,764	0	210,764	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,731,176		7,731,176	0	7,731,176	88.00
91.00	09100	EMERGENCY	3,084,565		3,084,565	0	3,084,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	401,770		401,770	0	401,770	92.00
200.00		Subtotal (see instructions)	23,826,143	0	23,826,143	0	23,826,143	200.00
201.00		Less Observation Beds	401,770		401,770	0	401,770	201.00
202.00		Total (see instructions)	23,424,373	0	23,424,373	0	23,424,373	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

			Title XIX			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,037,872		2,037,872			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	101,294	2,583,042	2,684,336	0.456288	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	29,246	737,786	767,032	0.097000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,451	5,426,578	5,499,029	0.343373	0.000000	54.00
56.00	05600	RADIOISOTOPE	5,481	592,852	598,333	0.143927	0.000000	56.00
57.00	05700	CT SCAN	130,404	7,872,890	8,003,294	0.004170	0.000000	57.00
58.00	05800	MRI	54,045	2,134,130	2,188,175	0.123392	0.000000	58.00
60.00	06000	LABORATORY	650,369	12,160,097	12,810,466	0.138845	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	318,744	160,462	479,206	0.601606	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	232,261	2,048,481	2,280,742	0.391403	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,967	467,617	530,584	0.409532	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,201	71,850	88,051	0.288004	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	67,730	2,581,321	2,649,051	0.153898	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,207	233,317	239,524	2.052304	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89,927	89,927	0.172618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,047,800	6,051,147	7,098,947	0.236463	0.000000	73.00
76.00	03950	DIABETIC SERVICES	1,926	31,781	33,707	6.252826	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,312,433	6,312,433	1.224754	0.000000	88.00
91.00	09100	EMERGENCY	134,229	8,314,136	8,448,365	0.365108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	45,339	295,481	340,820	1.178833	0.000000	92.00
200.00		Subtotal (see instructions)	5,014,566	58,165,328	63,179,894			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,014,566	58,165,328	63,179,894			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.456288			50.00
53.00	05300	ANESTHESIOLOGY	0.097000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.343373			54.00
56.00	05600	RADIOISOTOPE	0.143927			56.00
57.00	05700	CT SCAN	0.004170			57.00
58.00	05800	MRI	0.123392			58.00
60.00	06000	LABORATORY	0.138845			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.601606			65.00
66.00	06600	PHYSICAL THERAPY	0.391403			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.409532			67.00
68.00	06800	SPEECH PATHOLOGY	0.288004			68.00
69.00	06900	ELECTROCARDIOLOGY	0.153898			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2.052304			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.172618			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236463			73.00
76.00	03950	DIABETIC SERVICES	6.252826			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.224754			88.00
91.00	09100	EMERGENCY	0.365108			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.178833			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part II
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,224,830	208,991	1,015,839	0	50.00
53.00	05300	ANESTHESIOLOGY	74,402	10,511	63,891	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,888,218	290,852	1,597,366	0	54.00
56.00	05600	RADIOISOTOPE	86,116	3,852	82,264	0	56.00
57.00	05700	CT SCAN	33,375	7,625	25,750	0	57.00
58.00	05800	MRI	270,004	10,704	259,300	0	58.00
60.00	06000	LABORATORY	1,778,666	142,826	1,635,840	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	288,293	14,235	274,058	0	65.00
66.00	06600	PHYSICAL THERAPY	892,689	153,714	738,975	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,291	16,388	200,903	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,359	1,973	23,386	0	68.00
69.00	06900	ELECTROCARDIOLOGY	407,684	63,638	344,046	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	491,576	110,203	381,373	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,523	586	14,937	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,678,641	93,738	1,584,903	0	73.00
76.00	03950	DIABETIC SERVICES	210,764	40,998	169,766	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	7,731,176	696,818	7,034,358	0	88.00
91.00	09100	EMERGENCY	3,084,565	293,324	2,791,241	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	401,770	57,642	344,128	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	20,800,942	2,218,618	18,582,324	0	200.00
201.00		Less Observation Beds	401,770	57,642	344,128	0	201.00
202.00		Total (line 200 minus line 201)	20,399,172	2,160,976	18,238,196	0	202.00

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

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part II
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Title XIX		Hospital	PPS
			Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,224,830	2,684,336	0.456288	50.00
53.00	05300	ANESTHESIOLOGY	74,402	767,032	0.097000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,888,218	5,499,029	0.343373	54.00
56.00	05600	RADIOISOTOPE	86,116	598,333	0.143927	56.00
57.00	05700	CT SCAN	33,375	8,003,294	0.004170	57.00
58.00	05800	MRI	270,004	2,188,175	0.123392	58.00
60.00	06000	LABORATORY	1,778,666	12,810,466	0.138845	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	288,293	479,206	0.601606	65.00
66.00	06600	PHYSICAL THERAPY	892,689	2,280,742	0.391403	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,291	530,584	0.409532	67.00
68.00	06800	SPEECH PATHOLOGY	25,359	88,051	0.288004	68.00
69.00	06900	ELECTROCARDIOLOGY	407,684	2,649,051	0.153898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	491,576	239,524	2.052304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,523	89,927	0.172618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,678,641	7,098,947	0.236463	73.00
76.00	03950	DIABETIC SERVICES	210,764	33,707	6.252826	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,731,176	6,312,433	1.224754	88.00
91.00	09100	EMERGENCY	3,084,565	8,448,365	0.365108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	401,770	340,820	1.178833	92.00
200.00		Subtotal (sum of lines 50 thru 199)	20,800,942	61,142,022		200.00
201.00		Less Observation Beds	401,770	0		201.00
202.00		Total (line 200 minus line 201)	20,399,172	61,142,022		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/23/2021 1:22 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	208,991	2,684,336	0.077856	32,632	2,541	50.00
53.00	05300	ANESTHESIOLOGY	10,511	767,032	0.013703	9,397	129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	290,852	5,499,029	0.052892	26,772	1,416	54.00
56.00	05600	RADIOISOTOPE	3,852	598,333	0.006438	2,165	14	56.00
57.00	05700	CT SCAN	7,625	8,003,294	0.000953	35,107	33	57.00
58.00	05800	MRI	10,704	2,188,175	0.004892	12,713	62	58.00
60.00	06000	LABORATORY	142,826	12,810,466	0.011149	230,374	2,568	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	14,235	479,206	0.029705	123,695	3,674	65.00
66.00	06600	PHYSICAL THERAPY	153,714	2,280,742	0.067396	49,168	3,314	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,388	530,584	0.030887	10,328	319	67.00
68.00	06800	SPEECH PATHOLOGY	1,973	88,051	0.022407	10,584	237	68.00
69.00	06900	ELECTROCARDIOLOGY	63,638	2,649,051	0.024023	33,606	807	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110,203	239,524	0.460092	2,334	1,074	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	586	89,927	0.006516	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,738	7,098,947	0.013204	360,278	4,757	73.00
76.00	03950	DIABETIC SERVICES	40,998	33,707	1.216305	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	696,818	6,312,433	0.110388	0	0	88.00
91.00	09100	EMERGENCY	293,324	8,448,365	0.034720	4,207	146	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	57,642	340,820	0.169127	1,574	266	92.00
200.00		Total (lines 50 through 199)	2,218,618	61,142,022		944,934	21,357	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

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

Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:22 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	2,684,336	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	767,032	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,499,029	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	598,333	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	8,003,294	0.000000	57.00
58.00	05800	MRI	0	0	0	2,188,175	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	12,810,466	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	479,206	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,280,742	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	530,584	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	88,051	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,649,051	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	239,524	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	89,927	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,098,947	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	33,707	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,312,433	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	8,448,365	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	340,820	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	61,142,022		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

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

Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:22 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	32,632	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	9,397	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	26,772	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	2,165	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	35,107	0	0	0	57.00
58.00	05800	MRI	0.000000	12,713	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	230,374	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	123,695	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	49,168	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	10,328	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,584	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	33,606	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,334	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	360,278	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	4,207	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,574	0	0	0	92.00
200.00		Total (lines 50 through 199)		944,934	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/23/2021 1:22 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	0.456288	0	801,278	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.097000	0	221,522	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.343373	0	1,660,500	0	0	54.00	
56.00	05600	RADIOISOTOPE	0.143927	0	201,685	0	0	56.00	
57.00	05700	CT SCAN	0.004170	0	2,709,449	0	0	57.00	
58.00	05800	MRI	0.123392	0	616,622	0	0	58.00	
60.00	06000	LABORATORY	0.138845	0	4,070,873	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.601606	0	78,203	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.391403	0	601,454	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.409532	0	118,835	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.288004	0	30,845	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.153898	0	1,060,687	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2.052304	0	56,912	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.172618	0	9,515	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236463	0	3,140,999	6,390	0	73.00	
76.00	03950	DIABETIC SERVICES	6.252826	0	9,665	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC						88.00	
91.00	09100	EMERGENCY	0.365108	0	3,667,341	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.178833	0	175,364	0	0	92.00	
200.00		Subtotal (see instructions)		0	19,231,749	6,390	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	19,231,749	6,390	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1318		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part V Date/Time Prepared: 4/23/2021 1:22 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	365,614	0					50.00
53.00	05300	ANESTHESIOLOGY	21,488	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	570,171	0					54.00
56.00	05600	RADIOISOTOPE	29,028	0					56.00
57.00	05700	CT SCAN	11,298	0					57.00
58.00	05800	MRI	76,086	0					58.00
60.00	06000	LABORATORY	565,220	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
65.00	06500	RESPIRATORY THERAPY	47,047	0					65.00
66.00	06600	PHYSICAL THERAPY	235,411	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	48,667	0					67.00
68.00	06800	SPEECH PATHOLOGY	8,883	0					68.00
69.00	06900	ELECTROCARDIOLOGY	163,238	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	116,801	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,642	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	742,730	1,511					73.00
76.00	03950	DIABETIC SERVICES	60,434	0					76.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
91.00	09100	EMERGENCY	1,338,976	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	206,725	0					92.00
200.00		Subtotal (see instructions)	4,609,459	1,511					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	4,609,459	1,511					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	434,029	188,145	245,884	626	392.79	30.00
200.00	Total (lines 30 through 199)	434,029		245,884	626		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9	3,535				30.00
200.00	Total (lines 30 through 199)	9	3,535				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	208,991	2,684,336	0.077856	0	50.00
53.00	05300	ANESTHESIOLOGY	10,511	767,032	0.013703	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	290,852	5,499,029	0.052892	0	54.00
56.00	05600	RADIOISOTOPE	3,852	598,333	0.006438	0	56.00
57.00	05700	CT SCAN	7,625	8,003,294	0.000953	0	57.00
58.00	05800	MRI	10,704	2,188,175	0.004892	0	58.00
60.00	06000	LABORATORY	142,826	12,810,466	0.011149	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	14,235	479,206	0.029705	0	65.00
66.00	06600	PHYSICAL THERAPY	153,714	2,280,742	0.067396	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,388	530,584	0.030887	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,973	88,051	0.022407	0	68.00
69.00	06900	ELECTROCARDIOLOGY	63,638	2,649,051	0.024023	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110,203	239,524	0.460092	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	586	89,927	0.006516	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,738	7,098,947	0.013204	0	73.00
76.00	03950	DIABETIC SERVICES	40,998	33,707	1.216305	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	696,818	6,312,433	0.110388	0	88.00
91.00	09100	EMERGENCY	293,324	8,448,365	0.034720	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	57,642	340,820	0.169127	0	92.00
200.00		Total (lines 50 through 199)	2,218,618	61,142,022		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-1318		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/23/2021 1:22 pm	
					Title XIX		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	626	0.00	9	30.00		
200.00		Total (lines 30 through 199)		0	626		9	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

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

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Cost Center Description			Title XIX			Hospital		PPS	
			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	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

Period:
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Cost Center Description			Title XIX		Hospital		PPS
			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	2,684,336	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	767,032	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,499,029	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	598,333	0.000000
57.00	05700	CT SCAN	0	0	0	8,003,294	0.000000
58.00	05800	MRI	0	0	0	2,188,175	0.000000
60.00	06000	LABORATORY	0	0	0	12,810,466	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	479,206	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,280,742	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	530,584	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	88,051	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,649,051	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	239,524	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	89,927	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,098,947	0.000000
76.00	03950	DIABETIC SERVICES	0	0	0	33,707	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,312,433	0.000000
91.00	09100	EMERGENCY	0	0	0	8,448,365	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	340,820	0.000000
200.00		Total (lines 50 through 199)	0	0	0	61,142,022	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

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

Worksheet D
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				Title XIX		Hospital	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	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00	
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)		0	0	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

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

Worksheet D-1

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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)	1,137	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	626	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)	479	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	120	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)	359	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	24	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	329	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)	90	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)	268	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	159.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,025,201	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)	1,273	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)	3,819	25.00
26.00	Total swing-bed cost (see instructions)	1,314,261	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,710,940	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,710,940	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)	2,733.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	899,200	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)	899,200	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

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

Worksheet D-1

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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)					258,492	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,157,692	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)					245,982	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					732,479	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					978,461	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)					147	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,733.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					401,770	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1318		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/23/2021 1:22 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
								1.00	2.00
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	434,029	3,025,201	0.143471	401,770	57,642		90.00	
91.00	Nursing School cost	0	3,025,201	0.000000	401,770	0		91.00	
92.00	Allied health cost	0	3,025,201	0.000000	401,770	0		92.00	
93.00	All other Medical Education	0	3,025,201	0.000000	401,770	0		93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/23/2021 1:22 pm
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,137	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		626	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)		479	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		120	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)		359	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		8	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)		24	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		9	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,025,201	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		1,311,377	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,713,824	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,713,824	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)		2,737.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		24,640	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)		24,640	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

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

Worksheet D-1

Date/Time Prepared:
4/23/2021 1:22 pm

		Title XIX		Hospital		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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					24,640	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)					3,535	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)					3,535	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					21,105	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)					147	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,737.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					402,448	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1318		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/23/2021 1:22 pm	
				Title XIX		Hospital		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	434,029	3,025,201	0.143471	402,448	57,740		90.00	
91.00	Nursing School cost	0	3,025,201	0.000000	402,448	0		91.00	
92.00	Allied health cost	0	3,025,201	0.000000	402,448	0		92.00	
93.00	All other Medical Education	0	3,025,201	0.000000	402,448	0		93.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/23/2021 1:22 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		584,776		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.456288	32,632	14,890	50.00
53.00	05300 ANESTHESIOLOGY	0.097000	9,397	912	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.343373	26,772	9,193	54.00
56.00	05600 RADIOISOTOPE	0.143927	2,165	312	56.00
57.00	05700 CT SCAN	0.004170	35,107	146	57.00
58.00	05800 MRI	0.123392	12,713	1,569	58.00
60.00	06000 LABORATORY	0.138845	230,374	31,986	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.601606	123,695	74,416	65.00
66.00	06600 PHYSICAL THERAPY	0.391403	49,168	19,245	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.409532	10,328	4,230	67.00
68.00	06800 SPEECH PATHOLOGY	0.288004	10,584	3,048	68.00
69.00	06900 ELECTROCARDIOLOGY	0.153898	33,606	5,172	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2.052304	2,334	4,790	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.172618	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.236463	360,278	85,192	73.00
76.00	03950 DIABETIC SERVICES	6.252826	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.365108	4,207	1,536	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.178833	1,574	1,855	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		944,934	258,492	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)		944,934		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318 Component CCN: 14-Z318	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/23/2021 1:22 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.456288	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.097000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.343373	11,530	3,959	54.00
56.00	05600 RADIOISOTOPE	0.143927	0	0	56.00
57.00	05700 CT SCAN	0.004170	5,120	21	57.00
58.00	05800 MRI	0.123392	9,721	1,199	58.00
60.00	06000 LABORATORY	0.138845	132,820	18,441	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.601606	94,565	56,891	65.00
66.00	06600 PHYSICAL THERAPY	0.391403	106,505	41,686	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.409532	34,715	14,217	67.00
68.00	06800 SPEECH PATHOLOGY	0.288004	3,680	1,060	68.00
69.00	06900 ELECTROCARDIOLOGY	0.153898	442	68	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2.052304	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.172618	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.236463	274,675	64,950	73.00
76.00	03950 DIABETIC SERVICES	6.252826	1,926	12,043	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.365108	2,858	1,043	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.178833	2,590	3,053	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		681,147	218,631	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)		681,147		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1318	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/23/2021 1:22 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,610,970 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,610,970 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			4,657,080 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			41,584 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,810,846 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)			1,804,650 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)			1,804,650 30.00
31.00	Primary payer payments			50 31.00
32.00	Subtotal (line 30 minus line 31)			1,804,600 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)			183,585 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			119,330 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			50,040 36.00
37.00	Subtotal (see instructions)			1,923,930 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			1,923,930 40.00
40.01	Sequestration adjustment (see instructions)			22,318 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			1,523,715 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)			377,897 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: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/23/2021 1:22 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		942,029		1,345,488	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	09/22/2020	8,567	09/22/2020	61,683	3.01
3.02			0	05/28/2020	116,544	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	05/28/2020	5,991		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)		2,576		178,227	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)		944,605		1,523,715	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		100,568		377,897	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,045,173		1,901,612	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1318

Period:

Worksheet E-1

Component CCN: 14-Z318

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/23/2021 1:22 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,021,151		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	09/22/2020	18,721		0	3.01
3.02		05/28/2020	36,949		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)		55,670		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,076,821		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		109,443		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,186,264		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part II
Date/Time Prepared:
4/23/2021 1:22 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1318	Period: From 10/01/2019 To 09/30/2020	Worksheet E-2	
		Component CCN: 14-Z318		Date/Time Prepared: 4/23/2021 1:22 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		988,246	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)		220,817	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		358	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,209,063	0	8.00
9.00	Primary payer payments (see instructions)			0	9.00
10.00	Subtotal (line 8 minus line 9)		1,209,063	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,209,063	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		8,877	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,200,186	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,200,186	0	19.00
19.01	Sequestration adjustment (see instructions)		13,922	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		1,076,821	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)		109,443	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: 14-1318	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 4/23/2021 1:22 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,157,692	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)		1,157,692	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,169,269	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)		1,169,269	19.00
20.00	Deductibles (exclude professional component)		129,756	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,039,513	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,039,513	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		27,579	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		17,926	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,404	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,057,439	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)		1,057,439	30.00
30.01	Sequestration adjustment (see instructions)		12,266	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		944,605	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)		100,568	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1318

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

Worksheet G

Date/Time Prepared:
4/23/2021 1:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	350,082	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,981,707	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,896,397	0	0	0	6.00
7.00	Inventory	310,201	0	0	0	7.00
8.00	Prepaid expenses	14,473	0	0	0	8.00
9.00	Other current assets	49,401	0	0	0	9.00
10.00	Due from other funds	744	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,810,211	0	0	0	11.00
FIXED ASSETS						
12.00	Land	325,000	0	0	0	12.00
13.00	Land improvements	369,733	0	0	0	13.00
14.00	Accumulated depreciation	-281,714	0	0	0	14.00
15.00	Buildings	20,616,681	0	0	0	15.00
16.00	Accumulated depreciation	-6,205,952	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,515,880	0	0	0	23.00
24.00	Accumulated depreciation	-5,094,907	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	420,721	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,665,442	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	30,454,188	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,631,798	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	37,085,986	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,561,639	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	481,462	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,229	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	12,501	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,796,656	0	0	0	43.00
44.00	Other current liabilities	307,826	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,601,674	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	196,494	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	196,494	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,798,168	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	57,763,471				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)	57,763,471	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,561,639	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1318

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

Worksheet G-1

Date/Time Prepared:
4/23/2021 1:22 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		51,328,200		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,862,449				2.00
3.00	Total (sum of line 1 and line 2)		58,190,649		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		58,190,649		0		11.00
12.00	EQUITY TRANSFER	427,178		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)		427,178		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		57,763,471		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	EQUITY TRANSFER		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1318

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/23/2021 1:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,450,802		1,450,802	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	550,307		550,307	5.00
6.00	Swing bed - NF	36,764		36,764	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,037,873		2,037,873	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,037,873		2,037,873	17.00
18.00	Ancillary services	2,795,200	43,245,204	46,040,404	18.00
19.00	Outpatient services	179,568	8,609,617	8,789,185	19.00
20.00	RURAL HEALTH CLINIC	0	6,312,433	6,312,433	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	56,986	3,730,372	3,787,358	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,069,627	61,897,626	66,967,253	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,068,170		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)		27,068,170		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1318

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

Worksheet G-3

Date/Time Prepared:
4/23/2021 1:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,967,253	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,537,481	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,429,772	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,068,170	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,361,602	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	164,053	6.00
7.00	Income from investments	1,562,127	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	56,249	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	35,459	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	1,497,291	17.00
18.00	Revenue from sale of medical records and abstracts	3,933	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	4,450	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	164,914	24.00
24.50	COVID-19 PHE Funding	1,012,371	24.50
25.00	Total other income (sum of lines 6-24)	4,500,847	25.00
26.00	Total (line 5 plus line 25)	6,862,449	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)	6,862,449	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period:

Worksheet M-1

Component CCN: 14-3461

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/23/2021 1:22 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	792,419	0	792,419	-93,541	698,878
2.00	Physician Assistant	455,120	0	455,120	-7,158	447,962
3.00	Nurse Practitioner	402,582	0	402,582	-6,863	395,719
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	1,011,274	0	1,011,274	-10,359	1,000,915
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	127,458	0	127,458	-7,340	120,118
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	2,788,853	0	2,788,853	-125,261	2,663,592
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	15,898	15,898	0	15,898
14.00	Subtotal (sum of lines 11 through 13)	0	15,898	15,898	0	15,898
15.00	Medical Supplies	0	217,839	217,839	0	217,839
16.00	Transportation (Health Care Staff)	0	7,080	7,080	0	7,080
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	9,048	9,048	0	9,048
19.00	Other Health Care Costs	0	1,046	1,046	0	1,046
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	235,013	235,013	0	235,013
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,788,853	250,911	3,039,764	-125,261	2,914,503
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	53,630	53,630
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	53,630	53,630
FACILITY OVERHEAD						
29.00	Facility Costs	0	148,995	148,995	-140,286	8,709
30.00	Administrative Costs	319,890	1,482,557	1,802,447	-793,796	1,008,651
31.00	Total Facility Overhead (sum of lines 29 and 30)	319,890	1,631,552	1,951,442	-934,082	1,017,360
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,108,743	1,882,463	4,991,206	-1,005,713	3,985,493

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period:

Worksheet M-1

Component CCN: 14-3461

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/23/2021 1:22 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-12,041	686,837	1.00
2.00	Physician Assistant	-28,551	419,411	2.00
3.00	Nurse Practitioner	0	395,719	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,000,915	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	120,118	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-40,592	2,623,000	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	15,898	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	15,898	14.00
15.00	Medical Supplies	0	217,839	15.00
16.00	Transportation (Health Care Staff)	0	7,080	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	9,048	18.00
19.00	Other Health Care Costs	0	1,046	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	235,013	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-40,592	2,873,911	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	53,630	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	53,630	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	8,709	29.00
30.00	Administrative Costs	0	1,008,651	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,017,360	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-40,592	3,944,901	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1318

Period:

Worksheet M-2

Component CCN: 14-3461

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/23/2021 1:22 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.27	7,176	4,200	9,534		1.00
2.00	Physician Assistant	2.83	7,672	2,100	5,943		2.00
3.00	Nurse Practitioner	2.99	8,018	2,100	6,279		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.09	22,866		21,756	22,866	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	1.66	1,653			1,653	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	9.75	24,519			24,519	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,873,911	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					53,630	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,927,541	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.981681	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,017,360	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,786,275	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,803,635	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,803,635	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,715,637	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,589,548	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/23/2021 1:22 pm		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			7,589,548	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			273,764	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			7,315,784	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			24,519	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)			24,519	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			298.37	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)			298.37	298.37	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			1,292	3,875	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			385,494	1,156,184	11.00
12.00	Program covered visits for mental health services (from contractor records)			30	92	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			8,951	27,450	13.00
14.00	Limit adjustment for mental health services (see instructions)			8,951	27,450	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	1,578,079	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,152,829	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				2,796	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				3,827	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				1,169,969	16.04
16.05	Total program cost (see instructions)			0	1,173,796	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				111,791	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				207,599	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				1,173,796	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				83,878	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				1,257,674	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				1,257,674	26.00
26.01	Sequestration adjustment (see instructions)				14,589	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,143,905	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)				99,180	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1318 Component CCN:14-3461	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/23/2021 1:22 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,623,000	2,623,000	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000579	0.003025	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,519	7,935	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		61,443	32,769	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		62,962	40,704	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,873,911	2,873,911	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,715,637	4,715,637	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.021908	0.014163	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		103,310	66,788	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		166,272	107,492	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		415	2,170	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		400.66	49.54	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		127	666	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		50,884	32,994	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)			273,764	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)			83,878	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1318 Component CCN:14-3461	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/23/2021 1:22 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,063,796	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		05/28/2020	80,109	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		80,109	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,143,905	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		99,180	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,243,085	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00