

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: 14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/23/2021 1:21 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/23/2021	Time: 1:21 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 number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(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 SAINT LUKE MEDICAL CENTER (14-1325) 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	241,493	222,646	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	136,912	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		339,371		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	378,405	562,017	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: 14-1325		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/23/2021 1:21 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1051 WEST SOUTH STREET			PO Box: 747				1.00		
2.00	City: KEWANEE			State: IL		Zip Code: 61443		County: HENRY		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		OSF SAINT LUKE MEDICAL CENTER	141325	19340	1	07/01/1966	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		OSF SAINT LUKE SWING BED	14Z325	19340		03/19/2003	N	O	N
8.00	Swing Beds - NF		OSF SAINT LUKE SWING BED	14Z325	19340		03/19/2003	N		N
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		FAMILY HEALTH CLINIC	143445	19340		10/01/1998	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		
21.00	Type of Control (see instructions)						1			
							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				
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			
22.02	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			
22.03	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		
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1325

Period:
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Part I
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4/23/2021 1:21 pm

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

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			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		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		N	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		N	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		N	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)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	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	
				1.00			
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:	17,169		0		37,680 118.01	
				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1325		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/23/2021 1:21 pm	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149006		140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131		141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:				142.00	
143.00	City: PEORIA	State: IL		Zip Code: 61603		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			Y		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	Y		Y		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/23/2021 1:21 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: 14-1325		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part II Date/Time Prepared: 4/23/2021 1:21 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)	Y					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: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/23/2021 1:21 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			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.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REBECCA		ROBINSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-624-7644		REBECCA.C.ROBINSON@OSFHEALTHCARE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1325

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.	GOVT REPORTING ANALYST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/23/2021 1:21 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	22	8,052	29,940.26	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)		22	8,052	29,940.26	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,098	304.62	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	30,244.88	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/23/2021 1:21 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)	443	8	767		1.00
2.00	HMO and other (see instructions)	175	55			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	311	0	405		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	72		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	754	8	1,244		7.00
8.00	INTENSIVE CARE UNIT	11	3	21		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)	765	11	1,265	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	RHC (CONSOLIDATED)	6,482	8,439	27,235	0.00	55.45
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	201.33
28.00	Observation Bed Days		50	449		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: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/23/2021 1:21 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	189	10	415	1.00
2.00 HMO and other (see instructions)			59	33		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	189	10	415	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1325 Component CCN: 14-3445		Period: From 10/01/2019 To 09/30/2020		Worksheet S-8 Date/Time Prepared: 4/23/2021 1:21 pm	
		RHC I		Cost			
		1.00					
Clinic Address and Identification							
1.00	Street	1051 WEST SOUTH STREET				1.00	
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	KEWANEE IL 61443				2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
		1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)							
11.00	CLINIC	08:00		18:00		08:00	
		1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?	Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		3		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number	KEWANEE CLINIC		143445		14.00	
14.01		OSF MEDICAL GROUP SHEFFIELD		148594		14.01	
14.02		OSF MEDICAL GROUP GALVA		148595		14.02	
		Y/N	V	XVIII	XIX	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	HENRY				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	08:00	18:00	08:00	18:00	11.00

Health Financial Systems		OSF SAINT LUKE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1325	Period: From 10/01/2019	Worksheet S-8
			Component CCN: 14-3445	To 09/30/2020	Date/Time Prepared: 4/23/2021 1:21 pm
			RHC I		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
					14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00	08:00	12:00
					11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet S-10 Date/Time Prepared: 4/23/2021 1:21 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)			0.396836 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	3,234,618		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	16,048,440		6.00
7.00	Medicaid cost (line 1 times line 6)	6,368,599		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)	3,133,981		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)	3,133,981		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)	1,555,830	322,732	1,878,562 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	617,409	322,732	940,141 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	617,409	322,732	940,141 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,179,282		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	317,880		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	489,047		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,690,235		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	841,913		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,782,054		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,916,035		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1325

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

Worksheet A

Date/Time Prepared:
4/23/2021 1:21 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		571,903	571,903	30,595	602,498	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		507,604	507,604	0	507,604	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,500	906,226	912,726	2,428,436	3,341,162	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	800,813	6,521,523	7,322,336	-462,125	6,860,211	5.00
7.00	00700	OPERATION OF PLANT	287,771	1,473,412	1,761,183	-377,830	1,383,353	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	141,287	141,287	8.00
9.00	00900	HOUSEKEEPING	266,343	232,041	498,384	-194,877	303,507	9.00
10.00	01000	DIETARY	224,235	184,812	409,047	-373,138	35,909	10.00
11.00	01100	CAFETERIA	0	0	0	311,865	311,865	11.00
13.00	01300	NURSING ADMINISTRATION	5,507	8,267	13,774	-2,896	10,878	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,561	40,593	152,154	-32,866	119,288	14.00
15.00	01500	PHARMACY	184,708	581,097	765,805	3,941	769,746	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,326	23,408	107,734	-22,181	85,553	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	274,502	274,502	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,222,391	1,009,029	2,231,420	-295,411	1,936,009	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	20,552	20,552	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	499,914	551,579	1,051,493	-3,453	1,048,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	190,718	38,799	229,517	-20,228	209,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,203	90,719	383,922	269,729	653,651	54.00
54.01	03440	MAMMOGRAPHY	92,211	18,000	110,211	-14,959	95,252	54.01
56.00	05600	RADIOISOTOPE	0	125,224	125,224	-3,980	121,244	56.00
56.01	03630	ULTRA SOUND	207,513	61,330	268,843	-88,579	180,264	56.01
57.00	05700	CT SCAN	243,174	157,068	400,242	-61,193	339,049	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	140,228	26,059	166,287	-15,922	150,365	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	647,087	733,901	1,380,988	-123,655	1,257,333	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	63,159	63,159	2,111	65,270	62.00
65.00	06500	RESPIRATORY THERAPY	204,692	79,255	283,947	-43,989	239,958	65.00
66.00	06600	PHYSICAL THERAPY	514,794	153,173	667,967	-112,301	555,666	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,473	40,244	185,717	-26,960	158,757	67.00
68.00	06800	SPEECH PATHOLOGY	14,505	3,168	17,673	-1,594	16,079	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	165,414	42,929	208,343	-39,451	168,892	69.01
69.02	03650	VASCULAR LAB	0	0	0	36,279	36,279	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	88,503	88,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	541,420	541,420	0	541,420	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,252,899	2,328,488	6,581,387	-1,050,979	5,530,408	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,243,018	2,780,572	4,023,590	-233,819	3,789,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,048,998	19,895,002	31,944,000	5,414	31,949,414	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,700	29,554	37,254	-2,653	34,601	190.00
190.01	19001	FOUNDATION	7,700	79,827	87,527	-2,653	84,874	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,926	7,926	0	7,926	192.00
194.00	07950	INDUSTRIAL MEDICINE	590	108	698	-108	590	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	12,064,988	20,012,417	32,077,405	0	32,077,405	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1325

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

Worksheet A

Date/Time Prepared:
4/23/2021 1:21 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	784,586	1,387,084	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	738,218	1,245,822	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-111,385	3,229,777	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-853,979	6,006,232	5.00
7.00	00700	OPERATION OF PLANT	-5,437	1,377,916	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	141,287	8.00
9.00	00900	HOUSEKEEPING	0	303,507	9.00
10.00	01000	DIETARY	0	35,909	10.00
11.00	01100	CAFETERIA	-77,401	234,464	11.00
13.00	01300	NURSING ADMINISTRATION	243,990	254,868	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	119,288	14.00
15.00	01500	PHARMACY	-2,739	767,007	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,809	82,744	16.00
17.00	01700	SOCIAL SERVICE	-120,240	154,262	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-665,462	1,270,547	30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,552	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-180,188	867,852	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-206,003	3,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,442	670,093	54.00
54.01	03440	MAMMOGRAPHY	-186	95,066	54.01
56.00	05600	RADIOISOTOPE	0	121,244	56.00
56.01	03630	ULTRA SOUND	0	180,264	56.01
57.00	05700	CT SCAN	0	339,049	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	150,365	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-19,733	1,237,600	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	65,270	62.00
65.00	06500	RESPIRATORY THERAPY	0	239,958	65.00
66.00	06600	PHYSICAL THERAPY	-66,546	489,120	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	158,757	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,079	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	168,892	69.01
69.02	03650	VASCULAR LAB	0	36,279	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	88,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-541,420	0	73.00
73.01	03480	ONCOLOGY	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-265,368	5,265,040	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	-1,836,503	1,953,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,172,163	28,777,251	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,601	190.00
190.01	19001	FOUNDATION	0	84,874	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,926	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	590	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,172,163	28,905,242	200.00

RECLASSIFICATIONS

Provider CCN: 14-1325

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

Worksheet A-6

Date/Time Prepared:
4/23/2021 1:21 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LAUNDRY EXPENSES					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	141,287		1.00
	0		0	141,287		
	B - CLINICAL ENGINEERING					
1.00	LABORATORY	60.00	0	39,611		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	338,739		2.00
	0		0	378,350		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	201,082	110,783		1.00
	0		201,082	110,783		
	D - BLOOD COSTS					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	2,111	0		1.00
	0		2,111	0		
	F - RADIOLOGY SERVICES					
1.00	ULTRA SOUND	56.01	0	1,696		1.00
2.00	CT SCAN	57.00	0	1,696		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,696		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	596		4.00
	0		0	5,684		
	G - VASCULAR LAB SERVICES					
1.00	VASCULAR LAB	69.02	36,279	0		1.00
	0		36,279	0		
	H - MINISTRY ALLOCATIONS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	212,260		1.00
2.00	OPERATION OF PLANT	7.00	0	72,840		2.00
3.00	PHARMACY	15.00	0	43,704		3.00
4.00	SOCIAL SERVICE	17.00	0	274,502		4.00
5.00	PHYSICAL THERAPY	66.00	0	25,418		5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	7,067		6.00
7.00	SPEECH PATHOLOGY	68.00	0	672		7.00
	0		0	636,463		
	I - OTHER THERAPUTIC SERVICES					
1.00	OPERATING ROOM	50.00	20,660	0		1.00
	0		20,660	0		
	J - SURGEON RHC					
1.00	OPERATING ROOM	50.00	178,192	1,926		1.00
	0		178,192	1,926		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	88,503		1.00
	0		0	88,503		
	L - ICU COSTS					
1.00	INTENSIVE CARE UNIT	31.00	19,512	1,040		1.00
	0		19,512	1,040		
	Q - RHC SHARED BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	489,268		1.00
	0		0	489,268		
	R - REPAIRS AND MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	17,668		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
	0		0	17,668		
	S - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	30,595		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	329,684		2.00
	0		0	360,279		
	T - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,087,187		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

Provider CCN: 14-1325

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

Worksheet A-6

Date/Time Prepared:
4/23/2021 1:21 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
	0		0	2,087,187		
500.00	Grand Total: Increases		457,836	4,318,438		500.00

RECLASSIFICATIONS

Provider CCN: 14-1325

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

Worksheet A-6

Date/Time Prepared:
4/23/2021 1:21 pm

		Decreases				wkst. A-7 Ref.	
		Cost Center	Line #	Salary	Other		
		6.00	7.00	8.00	9.00	10.00	
A - LAUNDRY EXPENSES							
1.00	HOUSEKEEPING	9.00	0	141,287	0		1.00
	0		0	141,287			
B - CLINICAL ENGINEERING							
1.00	OPERATION OF PLANT	7.00	0	378,350	0		1.00
2.00	0	0.00	0	0	0		2.00
	0		0	378,350			
C - CAFETERIA							
1.00	DIETARY	10.00	201,082	110,783	0		1.00
	0		201,082	110,783			
D - BLOOD COSTS							
1.00	LABORATORY	60.00	2,111	0	0		1.00
	0		2,111	0			
F - RADIOLOGY SERVICES							
1.00	RADIOISOTOPE	56.00	0	3,980	0		1.00
2.00	MAMMOGRAPHY	54.01	0	1,704	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	5,684			
G - VASCULAR LAB SERVICES							
1.00	ULTRA SOUND	56.01	36,279	0	0		1.00
	0		36,279	0			
H - MINISTRY ALLOCATIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	636,463	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	636,463			
I - OTHER THERAPUTIC SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	20,660	0	0		1.00
	0		20,660	0			
J - SURGEON RHC							
1.00	RURAL HEALTH CLINIC	88.00	178,192	1,926	0		1.00
	0		178,192	1,926			
K - IMPLANTABLE DEVICES							
1.00	OPERATING ROOM	50.00	0	88,503	0		1.00
	0		0	88,503			
L - ICU COSTS							
1.00	ADULTS & PEDIATRICS	30.00	19,512	1,040	0		1.00
	0		19,512	1,040			
Q - RHC SHARED BENEFITS							
1.00	RURAL HEALTH CLINIC	88.00	0	489,268	0		1.00
	0		0	489,268			
R - REPAIRS AND MAINTENANCE							
1.00	DIETARY	10.00	0	7,105	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6	0		2.00
3.00	LABORATORY	60.00	0	3,467	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	595	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	280	0		5.00
6.00	RURAL HEALTH CLINIC	88.00	0	2,692	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	0	1,123	0		7.00
8.00	EMERGENCY	91.00	0	2,400	0		8.00
	0		0	17,668			
S - INSURANCE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	360,279	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	360,279			
T - BENEFITS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	155,346	0		1.00
2.00	OPERATION OF PLANT	7.00	0	89,988	0		2.00
3.00	HOUSEKEEPING	9.00	0	53,590	0		3.00
4.00	DIETARY	10.00	0	54,168	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,896	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	32,866	0		6.00
7.00	PHARMACY	15.00	0	39,763	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	22,181	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	254,199	0		9.00
10.00	OPERATING ROOM	50.00	0	115,728	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	20,228	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	69,600	0		12.00
13.00	MAMMOGRAPHY	54.01	0	13,255	0		13.00

Provider CCN: 14-1325

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

Worksheet A-6
Date/Time Prepared:
4/23/2021 1:21 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
14.00	ULTRA SOUND	56.01	0	53,996	0		14.00
15.00	CT SCAN	57.00	0	62,889	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	17,618	0		16.00
17.00	LABORATORY	60.00	0	157,688	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	43,989	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	137,124	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	34,027	0		20.00
21.00	SPEECH PATHOLOGY	68.00	0	2,266	0		21.00
22.00	CARDIOPULMONARY	69.01	0	39,451	0		22.00
23.00	RURAL HEALTH CLINIC	88.00	0	377,498	0		23.00
24.00	EMERGENCY	91.00	0	231,419	0		24.00
25.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2,653	0		25.00
26.00	FOUNDATION	190.01	0	2,653	0		26.00
27.00	INDUSTRIAL MEDICINE	194.00	0	108	0		27.00
	0		0	2,087,187			
500.00	Grand Total: Decreases		457,836	4,318,438			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,712,018	0	0	0	0	1.00	
2.00	Land Improvements	1,321,467	0	0	0	0	2.00	
3.00	Buildings and Fixtures	20,287,172	141,354	0	141,354	383,637	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	10,279,263	1,147,642	0	1,147,642	154,112	6.00	
7.00	HIT designated Assets	4,714,976	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	38,314,896	1,288,996	0	1,288,996	537,749	8.00	
9.00	Reconciling Items	285,496	83,023	0	83,023	0	9.00	
10.00	Total (line 8 minus line 9)	38,029,400	1,205,973	0	1,205,973	537,749	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,712,018	0				1.00	
2.00	Land Improvements	1,321,467	0				2.00	
3.00	Buildings and Fixtures	20,044,889	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	11,272,793	0				6.00	
7.00	HIT designated Assets	4,714,976	0				7.00	
8.00	Subtotal (sum of lines 1-7)	39,066,143	0				8.00	
9.00	Reconciling Items	368,519	0				9.00	
10.00	Total (line 8 minus line 9)	38,697,624	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/23/2021 1:21 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	571,903	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	507,604	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,079,507	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	571,903				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	507,604				2.00
3.00	Total (sum of lines 1-2)	0	1,079,507				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/23/2021 1:21 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	23,078,374	0	23,078,374	0.590751	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,987,769	0	15,987,769	0.409249	0	2.00
3.00	Total (sum of lines 1-2)	39,066,143	0	39,066,143	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,356,489	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,245,822	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,602,311	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed 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	30,595	0	0	1,387,084	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,245,822	2.00
3.00	Total (sum of lines 1-2)	0	30,595	0	0	2,632,906	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1325

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

Worksheet A-8

Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	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		0OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,544,771			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	392,933			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-77,401	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,809	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1325

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

Worksheet A-8

Date/Time Prepared:
4/23/2021 1:21 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	A	-25,186	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INC	B	-5,914	RURAL HEALTH CLINIC	88.00	0	33.00
33.01	MISC INC	B	-38,449	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INC	B	-24,433	PHYSICAL THERAPY	66.00	0	33.02
33.03	MISC INC	B	-2,739	PHARMACY	15.00	0	33.03
33.04	MISC INC	B	-56,437	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	MISC INC	A	-186	MAMMOGRAPHY	54.01	0	33.05
33.06	PROVIDER TAX	A	-903,321	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	CRNA - SALARY	A	-190,718	ANESTHESIOLOGY	53.00	0	33.07
33.08	CRNA - BENEFITS	A	-41,680	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	CRNA - OTHER EXPENSE	A	-15,285	ANESTHESIOLOGY	53.00	0	33.09
33.10	LOBBYING	A	-12,873	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	REAL ESTATE TAXES	A	-17,624	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	IMPAIRMENT OF ASSETS	A	413,833	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	IMPAIRMENT OF ASSETS	A	-38,200	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.13
33.14	PATIENT TRANSPORTATION	A	-156,549	EMERGENCY	91.00	0	33.14
33.15	NONALLOWABLE RHC COSTS	A	-1,048	RURAL HEALTH CLINIC	88.00	0	33.15
33.16	NONALLOWABLE RHC COSTS	A	-1,286	RURAL HEALTH CLINIC	88.00	0	33.16
33.17	NONALLOWABLE RHC COSTS	A	-488	RURAL HEALTH CLINIC	88.00	0	33.17
33.18	RE-LIFING OFFSET	A	597,900	CAP REL COSTS-BLDG & FIXT	1.00	9	33.18
33.19	RE-LIFING OFFSET	A	457,098	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	340B OFFSET	A	-541,420	DRUGS CHARGED TO PATIENTS	73.00	0	33.20
33.21	SPORTSCARE SALARIES	A	-40,168	PHYSICAL THERAPY	66.00	0	33.21
33.22	SPORTSCARE EXPENSES	A	-1,945	PHYSICAL THERAPY	66.00	0	33.22
33.23	SPORTSCARE BENEFITS	A	-8,777	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	PHYSICIAN BENEFITS	A	-52,626	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	OTHER OPERATING REVENUE - FARM INCOM	A	-17,875	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	PURCHASED SERVICES	A	-127,243	RURAL HEALTH CLINIC	88.00	0	33.26
33.27	HOSPITALISTS	A	-5,222	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	TREMONT BUILDING CLOSING COSTS	A	-72,952	RURAL HEALTH CLINIC	88.00	0	33.28
33.29	UROLOGY CLINIC MISCODED COMPENSATION	A	-8,302	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.29
33.30	UROLOGY CLINIC MISCODED BENEFITS		0		0.00	0	33.30
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,172,163				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: 14-1325

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

Worksheet A-8-1

Date/Time Prepared:
4/23/2021 1:21 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	89,004	316,151	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	344,506	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO POOLED - ADMIN & GENERAL	2,643,515	3,413,027	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	212,260	212,260	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	317,974	317,974	3.02
3.03	30.00	ADULTS & PEDIATRICS	MINISTRY ALLOCATION	3,216	3,216	3.03
3.04	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	25,418	25,418	3.04
3.05	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	7,067	7,067	3.05
3.06	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	672	672	3.06
3.07	15.00	PHARMACY	MINISTRY ALLOCATION	43,704	43,704	3.07
3.08	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	97,339	97,339	3.08
3.09	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	127,882	218,615	3.09
3.10	60.00	LABORATORY	MINISTRY ALLOCATION	25,541	25,541	3.10
3.11	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	243,990	0	3.11
3.12	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	154,262	274,502	3.12
3.13	5.00	ADMINISTRATIVE & GENERAL	HO FUNCTIONAL - ADMIN & GEN	1,911,346	1,000,678	3.13
3.14	54.00	RADIOLOGY-DIAGNOSTIC	SFI ETS	112,024	0	3.14
3.15	5.00	ADMINISTRATIVE & GENERAL	SFI CVO	54,694	54,465	3.15
3.16	7.00	OPERATION OF PLANT	SFI HEALTHCARE TECHNOLOGY SV	129,269	134,706	3.16
3.17	54.00	RADIOLOGY-DIAGNOSTIC	SFI HEALTHCARE TECHNOLOGY SV	115,284	120,133	3.17
4.00	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	13,469	14,035	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,672,436	6,279,503	5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-1325

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

Worksheet A-8-1

Date/Time Prepared:
4/23/2021 1:21 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	-227,147	9		1.00
2.00	344,506	9		2.00
3.00	-769,512	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	-90,733	0		3.09
3.10	0	0		3.10
3.11	243,990	0		3.11
3.12	-120,240	0		3.12
3.13	910,668	0		3.13
3.14	112,024	0		3.14
3.15	229	0		3.15
3.16	-5,437	0		3.16
3.17	-4,849	0		3.17
4.00	-566	0		4.00
5.00	392,933			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1325

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

Worksheet A-8-2

Date/Time Prepared:
4/23/2021 1:21 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	665,462	665,462	0	0	0	1.00
2.00	50.00	OPERATING ROOM	180,188	180,188	0	0	0	2.00
3.00	60.00	LABORATORY	19,167	19,167	0	0	0	3.00
4.00	91.00	EMERGENCY	2,213,378	1,679,954	533,424	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,078,195	2,544,771	533,424		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	50.00	OPERATING ROOM	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	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	665,462		1.00
2.00	50.00	OPERATING ROOM	0	0	0	180,188		2.00
3.00	60.00	LABORATORY	0	0	0	19,167		3.00
4.00	91.00	EMERGENCY	0	0	0	1,679,954		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,544,771		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:21 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	1,387,084	1,387,084			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,245,822		1,245,822		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,229,777	0	57	3,229,834	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,006,232	222,311	336,670	223,559	5.00
7.00	00700	OPERATION OF PLANT	1,377,916	115,105	49,045	80,336	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	141,287	5,861	0	0	8.00
9.00	00900	HOUSEKEEPING	303,507	11,270	0	74,354	9.00
10.00	01000	DIETARY	35,909	31,374	7,724	6,464	10.00
11.00	01100	CAFETERIA	234,464	10,704	0	56,135	11.00
13.00	01300	NURSING ADMINISTRATION	254,868	4,078	0	1,537	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	119,288	0	0	31,144	14.00
15.00	01500	PHARMACY	767,007	19,269	32,633	51,564	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	82,744	26,660	76	23,541	16.00
17.00	01700	SOCIAL SERVICE	154,262	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,270,547	255,626	69,380	328,965	30.00
31.00	03100	INTENSIVE CARE UNIT	20,552	36,131	0	5,447	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	867,852	135,705	109,430	145,308	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,286	1,911	16,725	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,093	64,688	128,101	81,853	54.00
54.01	03440	MAMMOGRAPHY	95,066	2,449	27,523	25,742	54.01
56.00	05600	RADIOISOTOPE	121,244	3,823	0	0	56.00
56.01	03630	ULTRA SOUND	180,264	3,313	2,885	47,803	56.01
57.00	05700	CT SCAN	339,049	5,352	81,278	67,886	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	150,365	26,646	242,857	39,147	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,237,600	27,976	79,733	180,056	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	65,270	2,548	0	589	62.00
65.00	06500	RESPIRATORY THERAPY	239,958	7,900	10,542	57,143	65.00
66.00	06600	PHYSICAL THERAPY	489,120	47,685	1,395	132,500	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,757	4,332	0	40,611	67.00
68.00	06800	SPEECH PATHOLOGY	16,079	1,529	689	4,049	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	168,892	28,656	19,668	46,178	69.01
69.02	03650	VASCULAR LAB	36,279	1,529	0	10,128	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,503	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,265,040	132,860	8,892	1,116,320	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,953,268	99,999	13,512	347,010	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,777,251	1,337,290	1,238,815	3,225,369	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	34,601	12,955	0	2,150	190.00
190.01	19001	FOUNDATION	84,874	0	5,204	2,150	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	1,803	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,926	36,839	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	590	0	0	165	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	28,905,242	1,387,084	1,245,822	3,229,834	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	6,788,772					5.00
7.00	00700	OPERATION OF PLANT	498,004	2,120,406				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,168	11,841	204,157			8.00
9.00	00900	HOUSEKEEPING	119,446	22,766	22,604	553,947		9.00
10.00	01000	DIETARY	25,008	63,379	0	5,740	175,598	10.00
11.00	01100	CAFETERIA	92,486	21,622	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	79,957	8,237	0	8,037	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,176	0	105	8,037	0	14.00
15.00	01500	PHARMACY	267,196	38,925	0	13,394	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,831	53,855	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	47,351	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	590,740	516,381	53,963	203,210	172,683	30.00
31.00	03100	INTENSIVE CARE UNIT	19,071	72,988	0	3,636	2,915	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	386,240	274,135	8,401	68,119	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	6,729	3,861	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	289,991	130,675	11,499	54,916	0	54.00
54.01	03440	MAMMOGRAPHY	46,283	4,948	0	0	0	54.01
56.00	05600	RADIOISOTOPE	38,390	7,722	0	0	0	56.00
56.01	03630	ULTRA SOUND	71,909	6,692	0	0	0	56.01
57.00	05700	CT SCAN	151,502	10,811	0	8,611	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	140,897	53,826	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	468,218	56,514	0	27,171	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	20,998	5,148	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	96,858	15,959	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	205,875	96,326	22,315	30,424	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,527	8,752	0	6,506	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,859	3,089	0	5,932	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	80,850	57,887	6,471	15,116	0	69.01
69.02	03650	VASCULAR LAB	14,714	3,089	0	5,549	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,166	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,002,313	268,386	0	25,640	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	740,925	202,005	78,799	54,342	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,730,678	2,019,819	204,157	544,380	175,598	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,258	26,169	0	0	0	190.00
190.01	19001	FOUNDATION	28,310	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	553	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,741	74,418	0	9,567	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	232	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,788,772	2,120,406	204,157	553,947	175,598	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
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
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	415,411					11.00
13.00	01300	NURSING ADMINISTRATION	138	356,852				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,066	0	209,816			14.00
15.00	01500	PHARMACY	5,703	13,006	3,529	1,212,226		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,742	0	73	0	238,522	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	69,987	159,611	14,426	0	7,831	30.00
31.00	03100	INTENSIVE CARE UNIT	1,135	2,589	0	0	241	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	30,509	69,577	70,458	0	18,948	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,796	0	862	0	3,906	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,036	0	1,051	0	10,063	54.00
54.01	03440	MAMMOGRAPHY	4,457	0	364	0	2,160	54.01
56.00	05600	RADIOISOTOPE	0	0	268	0	2,223	56.00
56.01	03630	ULTRA SOUND	12,735	0	1,125	0	4,089	56.01
57.00	05700	CT SCAN	18,936	0	8,466	0	31,670	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,201	0	456	0	9,552	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	35,464	0	50,228	0	50,128	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	111	0	0	0	918	62.00
65.00	06500	RESPIRATORY THERAPY	11,766	0	3,512	0	3,958	65.00
66.00	06600	PHYSICAL THERAPY	16,777	0	226	0	8,236	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,433	0	19	0	1,958	67.00
68.00	06800	SPEECH PATHOLOGY	526	0	0	0	278	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	10,880	0	386	0	7,173	69.01
69.02	03650	VASCULAR LAB	1,938	0	0	0	1,776	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,212,226	13,535	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	101,660	0	16,714	0	28,131	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	49,141	112,069	37,563	0	30,151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	414,137	356,852	209,726	1,212,226	238,522	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	637	0	0	0	0	190.00
190.01	19001	FOUNDATION	637	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	90	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	0	194.00
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)	415,411	356,852	209,816	1,212,226	238,522	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
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	201,613				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	198,266	3,911,616	0	3,911,616	30.00
31.00	03100	INTENSIVE CARE UNIT	3,347	168,052	0	168,052	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,184,682	0	2,184,682	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	40,076	0	40,076	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,456,966	0	1,456,966	54.00
54.01	03440	MAMMOGRAPHY	0	208,992	0	208,992	54.01
56.00	05600	RADIOISOTOPE	0	173,670	0	173,670	56.00
56.01	03630	ULTRA SOUND	0	330,815	0	330,815	56.01
57.00	05700	CT SCAN	0	723,561	0	723,561	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	669,947	0	669,947	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,213,088	0	2,213,088	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	95,582	0	95,582	62.00
65.00	06500	RESPIRATORY THERAPY	0	447,596	0	447,596	65.00
66.00	06600	PHYSICAL THERAPY	0	1,050,879	0	1,050,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	286,895	0	286,895	67.00
68.00	06800	SPEECH PATHOLOGY	0	39,030	0	39,030	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	442,157	0	442,157	69.01
69.02	03650	VASCULAR LAB	0	75,002	0	75,002	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	117,266	0	117,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,225,761	0	1,225,761	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	8,965,956	0	8,965,956	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	3,718,784	0	3,718,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	201,613	28,546,373	0	28,546,373	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	91,770	0	91,770	190.00
190.01	19001	FOUNDATION	0	121,175	0	121,175	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	2,356	0	2,356	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	142,581	0	142,581	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	987	0	987	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	201,613	28,905,242	0	28,905,242	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	57	57	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	222,311	336,670	558,981	5.00
7.00	00700	OPERATION OF PLANT	0	115,105	49,045	164,150	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,861	0	5,861	8.00
9.00	00900	HOUSEKEEPING	0	11,270	0	11,270	9.00
10.00	01000	DIETARY	0	31,374	7,724	39,098	10.00
11.00	01100	CAFETERIA	0	10,704	0	10,704	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,078	0	4,078	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	19,269	32,633	51,902	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,660	76	26,736	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	255,626	69,380	325,006	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,131	0	36,131	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	135,705	109,430	245,135	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,911	16,725	18,636	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,688	128,101	192,789	54.00
54.01	03440	MAMMOGRAPHY	0	2,449	27,523	29,972	54.01
56.00	05600	RADIOISOTOPE	0	3,823	0	3,823	56.00
56.01	03630	ULTRA SOUND	0	3,313	2,885	6,198	56.01
57.00	05700	CT SCAN	0	5,352	81,278	86,630	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,646	242,857	269,503	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	27,976	79,733	107,709	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,548	0	2,548	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,900	10,542	18,442	65.00
66.00	06600	PHYSICAL THERAPY	0	47,685	1,395	49,080	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,332	0	4,332	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,529	689	2,218	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	28,656	19,668	48,324	69.01
69.02	03650	VASCULAR LAB	0	1,529	0	1,529	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	132,860	8,892	141,752	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	99,999	13,512	113,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,337,290	1,238,815	2,576,105	57 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,955	0	12,955	190.00
190.01	19001	FOUNDATION	0	0	5,204	5,204	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	1,803	1,803	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,839	0	36,839	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,387,084	1,245,822	2,632,906	57 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	558,985					5.00
7.00	00700	OPERATION OF PLANT	41,006	205,157				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,719	1,146	10,726			8.00
9.00	00900	HOUSEKEEPING	9,835	2,203	1,188	24,497		9.00
10.00	01000	DIETARY	2,059	6,132	0	254	47,543	10.00
11.00	01100	CAFETERIA	7,615	2,092	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,584	797	0	355	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,802	0	6	355	0	14.00
15.00	01500	PHARMACY	22,001	3,766	0	592	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,362	5,211	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,899	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	48,642	49,959	2,835	8,988	46,754	30.00
31.00	03100	INTENSIVE CARE UNIT	1,570	7,062	0	161	789	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,803	26,524	441	3,012	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	554	374	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,878	12,643	604	2,429	0	54.00
54.01	03440	MAMMOGRAPHY	3,811	479	0	0	0	54.01
56.00	05600	RADIOISOTOPE	3,161	747	0	0	0	56.00
56.01	03630	ULTRA SOUND	5,921	648	0	0	0	56.01
57.00	05700	CT SCAN	12,475	1,046	0	381	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,602	5,208	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	38,554	5,468	0	1,202	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,729	498	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	7,975	1,544	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	16,952	9,320	1,172	1,345	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,149	847	0	288	0	67.00
68.00	06800	SPEECH PATHOLOGY	565	299	0	262	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	6,657	5,601	340	668	0	69.01
69.02	03650	VASCULAR LAB	1,212	299	0	245	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,237	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	164,864	25,967	0	1,134	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	61,009	19,545	4,140	2,403	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	554,202	195,425	10,726	24,074	47,543	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,256	2,532	0	0	0	190.00
190.01	19001	FOUNDATION	2,331	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	46	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,131	7,200	0	423	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	19	0	0	0	0	194.00
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)	558,985	205,157	10,726	24,497	47,543	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
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
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	20,412					11.00
13.00	01300	NURSING ADMINISTRATION	7	11,821				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	249	0	4,413			14.00
15.00	01500	PHARMACY	280	431	74	79,047		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	528	0	2	0	35,839	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,439	5,287	303	0	1,176	30.00
31.00	03100	INTENSIVE CARE UNIT	56	86	0	0	36	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,499	2,305	1,480	0	2,846	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	137	0	18	0	587	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	690	0	22	0	1,511	54.00
54.01	03440	MAMMOGRAPHY	219	0	8	0	324	54.01
56.00	05600	RADIOISOTOPE	0	0	6	0	334	56.00
56.01	03630	ULTRA SOUND	626	0	24	0	614	56.01
57.00	05700	CT SCAN	930	0	178	0	4,756	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	305	0	10	0	1,435	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,743	0	1,057	0	7,545	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5	0	0	0	138	62.00
65.00	06500	RESPIRATORY THERAPY	578	0	74	0	594	65.00
66.00	06600	PHYSICAL THERAPY	824	0	5	0	1,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	169	0	0	0	294	67.00
68.00	06800	SPEECH PATHOLOGY	26	0	0	0	42	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	535	0	8	0	1,077	69.01
69.02	03650	VASCULAR LAB	95	0	0	0	267	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	79,047	2,033	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,995	0	352	0	4,225	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,415	3,712	790	0	4,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,350	11,821	4,411	79,047	35,839	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31	0	0	0	0	190.00
190.01	19001	FOUNDATION	31	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	0	194.00
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)	20,412	11,821	4,413	79,047	35,839	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
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	3,899				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,834	496,229	0	496,229	30.00
31.00	03100	INTENSIVE CARE UNIT	65	45,956	0	45,956	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	315,048	0	315,048	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	20,306	0	20,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	234,567	0	234,567	54.00
54.01	03440	MAMMOGRAPHY	0	34,813	0	34,813	54.01
56.00	05600	RADIOISOTOPE	0	8,071	0	8,071	56.00
56.01	03630	ULTRA SOUND	0	14,032	0	14,032	56.01
57.00	05700	CT SCAN	0	106,397	0	106,397	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	288,064	0	288,064	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	163,281	0	163,281	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,918	0	4,918	62.00
65.00	06500	RESPIRATORY THERAPY	0	29,208	0	29,208	65.00
66.00	06600	PHYSICAL THERAPY	0	79,937	0	79,937	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,080	0	11,080	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,412	0	3,412	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	63,211	0	63,211	69.01
69.02	03650	VASCULAR LAB	0	3,647	0	3,647	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,477	0	2,477	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	81,080	0	81,080	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	343,310	0	343,310	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	212,059	0	212,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,899	2,561,103	0	2,561,103	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,774	0	16,774	190.00
190.01	19001	FOUNDATION	0	7,566	0	7,566	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	1,849	0	1,849	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	45,595	0	45,595	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	19	0	19	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,899	2,632,906	0	2,632,906	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1325

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

Worksheet B-1

Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,971					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,302,872				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	60	11,569,541			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,702	352,087	800,806	-6,788,772	22,116,470	5.00
7.00	00700	OPERATION OF PLANT	8,130	51,291	287,771	0	1,622,402	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	0	0	0	147,148	8.00
9.00	00900	HOUSEKEEPING	796	0	266,343	0	389,131	9.00
10.00	01000	DIETARY	2,216	8,078	23,153	0	81,471	10.00
11.00	01100	CAFETERIA	756	0	201,082	0	301,303	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	5,507	0	260,483	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	111,561	0	150,432	14.00
15.00	01500	PHARMACY	1,361	34,127	184,708	0	870,473	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	79	84,326	0	133,021	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	154,262	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,055	72,557	1,178,379	0	1,924,518	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	0	19,512	0	62,130	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,585	114,441	520,504	0	1,258,295	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	17,491	0	0	21,922	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,569	133,967	293,203	0	944,735	54.00
54.01	03440	MAMMOGRAPHY	173	28,783	92,211	0	150,780	54.01
56.00	05600	RADIOISOTOPE	270	0	0	0	125,067	56.00
56.01	03630	ULTRA SOUND	234	3,017	171,234	0	234,265	56.01
57.00	05700	CT SCAN	378	85,000	243,174	0	493,565	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,882	253,978	140,228	0	459,015	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	83,384	644,976	0	1,525,365	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	2,111	0	68,407	62.00
65.00	06500	RESPIRATORY THERAPY	558	11,025	204,692	0	315,543	65.00
66.00	06600	PHYSICAL THERAPY	3,368	1,459	474,626	0	670,700	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	145,473	0	203,700	67.00
68.00	06800	SPEECH PATHOLOGY	108	721	14,505	0	22,346	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	2,024	20,569	165,414	0	263,394	69.01
69.02	03650	VASCULAR LAB	108	0	36,279	0	47,936	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	88,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	9,384	9,299	3,998,755	0	6,523,112	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	14,131	1,243,018	0	2,413,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,454	1,295,544	11,553,551	-6,788,772	21,927,213	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	7,700	0	49,706	190.00
190.01	19001	FOUNDATION	0	5,442	7,700	0	92,228	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	1,886	0	0	1,803	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	0	0	44,765	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	590	0	755	194.00
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)	1,387,084	1,245,822	3,229,834		6,788,772	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.158108	0.956212	0.279167		0.306955	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			57		558,985	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000005		0.025275	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1325

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

Worksheet B-1

Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1325

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

Worksheet B-1

Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
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
7.00	00700	OPERATION OF PLANT	74,139				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	15,553			8.00
9.00	00900	HOUSEKEEPING	796	1,722	2,895		9.00
10.00	01000	DIETARY	2,216	0	30	1,265	10.00
11.00	01100	CAFETERIA	756	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	42	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8	42	0	14.00
15.00	01500	PHARMACY	1,361	0	70	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,055	4,111	1,062	1,244	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	0	19	21	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,585	640	356	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,569	876	287	0	54.00
54.01	03440	MAMMOGRAPHY	173	0	0	0	54.01
56.00	05600	RADIOISOTOPE	270	0	0	0	56.00
56.01	03630	ULTRA SOUND	234	0	0	0	56.01
57.00	05700	CT SCAN	378	0	45	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,882	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	0	142	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,368	1,700	159	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	34	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	31	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	2,024	493	79	0	69.01
69.02	03650	VASCULAR LAB	108	0	29	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	9,384	0	134	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	6,003	284	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,622	15,553	2,845	1,265	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	50	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	194.00
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)	2,120,406	204,157	553,947	175,598	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.600413	13.126535	191.346114	138.812648	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	205,157	10,726	24,497	47,543	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.767194	0.689642	8.461831	37.583399	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: 14-1325

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

Worksheet B-1

Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description		NURSING ADMINISTRATIO N (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	5,652				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	769,807			14.00
15.00	01500	PHARMACY	206	12,949	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	268	0	71,934,919	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,265	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,528	52,928	0	2,361,467	30.00
31.00	03100	INTENSIVE CARE UNIT	41	0	0	72,646	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,102	258,499	0	5,714,004	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,164	0	1,177,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,855	0	3,034,654	54.00
54.01	03440	MAMMOGRAPHY	0	1,337	0	651,431	54.01
56.00	05600	RADIOISOTOPE	0	985	0	670,278	56.00
56.01	03630	ULTRA SOUND	0	4,128	0	1,233,096	56.01
57.00	05700	CT SCAN	0	31,063	0	9,550,681	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,673	0	2,880,533	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	184,286	0	15,121,508	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	276,968	62.00
65.00	06500	RESPIRATORY THERAPY	0	12,884	0	1,193,743	65.00
66.00	06600	PHYSICAL THERAPY	0	830	0	2,483,818	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	71	0	590,476	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	83,743	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,415	0	2,163,075	69.01
69.02	03650	VASCULAR LAB	0	0	0	535,476	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	481,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	4,081,766	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	61,323	0	8,483,381	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,775	137,818	0	9,092,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,652	769,476	100	71,934,919	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	330	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	194.00
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)	356,852	209,816	1,212,226	238,522	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	63.137297	0.272557	12,122.260000	0.003316	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,821	4,413	79,047	35,839	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.091472	0.005733	790.470000	0.000498	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: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,911,616		3,911,616	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	168,052		168,052	0	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,184,682		2,184,682	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	40,076		40,076	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,456,966		1,456,966	0	0	54.00
54.01	03440	MAMMOGRAPHY	208,992		208,992	0	0	54.01
56.00	05600	RADIOISOTOPE	173,670		173,670	0	0	56.00
56.01	03630	ULTRA SOUND	330,815		330,815	0	0	56.01
57.00	05700	CT SCAN	723,561		723,561	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	669,947		669,947	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,213,088		2,213,088	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	95,582		95,582	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	447,596	0	447,596	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,050,879	0	1,050,879	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	286,895	0	286,895	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,030	0	39,030	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	442,157		442,157	0	0	69.01
69.02	03650	VASCULAR LAB	75,002		75,002	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,266		117,266	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,225,761		1,225,761	0	0	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,965,956		8,965,956	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,718,784		3,718,784	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,080,303		1,080,303	0	0	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,626,676	0	29,626,676	0	0	200.00
201.00		Less Observation Beds	1,080,303		1,080,303			201.00
202.00		Total (see instructions)	28,546,373	0	28,546,373	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:21 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	2,012,007		2,012,007		30.00
31.00	03100	INTENSIVE CARE UNIT	72,646		72,646		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	243,839	5,470,165	5,714,004	0.382338	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	84,744	1,093,059	1,177,803	0.034026	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,600	2,947,054	3,034,654	0.480109	54.00
54.01	03440	MAMMOGRAPHY	0	651,431	651,431	0.320820	54.01
56.00	05600	RADIOISOTOPE	14,171	656,107	670,278	0.259101	56.00
56.01	03630	ULTRA SOUND	11,075	1,222,021	1,233,096	0.268280	56.01
57.00	05700	CT SCAN	266,082	9,284,599	9,550,681	0.075760	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,434	2,860,099	2,880,533	0.232577	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	774,186	14,347,322	15,121,508	0.146354	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	53,229	223,739	276,968	0.345101	62.00
65.00	06500	RESPIRATORY THERAPY	187,925	1,005,818	1,193,743	0.374952	65.00
66.00	06600	PHYSICAL THERAPY	308,413	2,175,405	2,483,818	0.423090	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,034	390,442	590,476	0.485871	67.00
68.00	06800	SPEECH PATHOLOGY	16,464	67,279	83,743	0.466069	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	166,273	1,996,802	2,163,075	0.204411	69.01
69.02	03650	VASCULAR LAB	14,648	520,828	535,476	0.140066	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,321	471,381	481,702	0.243441	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	840,587	3,241,179	4,081,766	0.300302	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	73.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,483,381	8,483,381		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	211,800	8,880,870	9,092,670	0.408987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	49,517	299,943	349,460	3.091350	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,645,995	66,288,924	71,934,919		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,645,995	66,288,924	71,934,919		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet C
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03440	MAMMOGRAPHY	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
56.01	03630	ULTRA SOUND	0.000000			56.01
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	03160	CARDIOPULMONARY	0.000000			69.01
69.02	03650	VASCULAR LAB	0.000000			69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,911,616		3,911,616	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	168,052		168,052	0	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,184,682		2,184,682	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	40,076		40,076	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,456,966		1,456,966	0	0	54.00
54.01	03440	MAMMOGRAPHY	208,992		208,992	0	0	54.01
56.00	05600	RADIOISOTOPE	173,670		173,670	0	0	56.00
56.01	03630	ULTRA SOUND	330,815		330,815	0	0	56.01
57.00	05700	CT SCAN	723,561		723,561	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	669,947		669,947	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,213,088		2,213,088	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	95,582		95,582	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	447,596	0	447,596	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,050,879	0	1,050,879	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	286,895	0	286,895	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,030	0	39,030	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	442,157		442,157	0	0	69.01
69.02	03650	VASCULAR LAB	75,002		75,002	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,266		117,266	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,225,761		1,225,761	0	0	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,965,956		8,965,956	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,718,784		3,718,784	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,546,373	0	28,546,373	0	0	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	28,546,373	0	28,546,373	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

			Title XIX		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	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	03650	VASCULAR LAB	0	0	0	0.000000	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
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4/23/2021 1:21 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03440	MAMMOGRAPHY	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
56.01	03630	ULTRA SOUND	0.000000			56.01
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	03160	CARDIOPULMONARY	0.000000			69.01
69.02	03650	VASCULAR LAB	0.000000			69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	315,048	5,714,004	0.055136	126,446	6,972	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	20,306	1,177,803	0.017241	43,327	747	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	234,567	3,034,654	0.077296	24,862	1,922	54.00
54.01	03440 MAMMOGRAPHY	34,813	651,431	0.053441	0	0	54.01
56.00	05600 RADIOISOTOPE	8,071	670,278	0.012041	3,201	39	56.00
56.01	03630 ULTRA SOUND	14,032	1,233,096	0.011379	1,864	21	56.01
57.00	05700 CT SCAN	106,397	9,550,681	0.011140	63,120	703	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	288,064	2,880,533	0.100004	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	163,281	15,121,508	0.010798	285,670	3,085	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4,918	276,968	0.017757	19,497	346	62.00
65.00	06500 RESPIRATORY THERAPY	29,208	1,193,743	0.024468	84,401	2,065	65.00
66.00	06600 PHYSICAL THERAPY	79,937	2,483,818	0.032183	61,167	1,969	66.00
67.00	06700 OCCUPATIONAL THERAPY	11,080	590,476	0.018765	37,164	697	67.00
68.00	06800 SPEECH PATHOLOGY	3,412	83,743	0.040744	7,969	325	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160 CARDIOPULMONARY	63,211	2,163,075	0.029223	82,194	2,402	69.01
69.02	03650 VASCULAR LAB	3,647	535,476	0.006811	7,140	49	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,477	481,702	0.005142	4,616	24	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	81,080	4,081,766	0.019864	308,660	6,131	73.00
73.01	03480 ONCOLOGY	0	0	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	343,310	8,483,381	0.040469	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	212,059	9,092,670	0.023322	3,772	88	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	137,047	349,460	0.392168	3,416	1,340	92.00
200.00	Total (lines 50 through 199)	2,155,965	69,850,266		1,168,486	28,925	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:21 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:21 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	5,714,004	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,177,803	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,034,654	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	651,431	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	670,278	0.000000	56.00
56.01	03630	ULTRA SOUND	0	0	0	1,233,096	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	9,550,681	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,880,533	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	15,121,508	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	276,968	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,193,743	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,483,818	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	590,476	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	83,743	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	2,163,075	0.000000	69.01
69.02	03650	VASCULAR LAB	0	0	0	535,476	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	481,702	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,081,766	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,483,381	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	9,092,670	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	349,460	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	69,850,266		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	126,446	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	43,327	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	24,862	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	3,201	0	0	0	56.00
56.01	03630	ULTRA SOUND	0.000000	1,864	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	63,120	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	285,670	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	19,497	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	84,401	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	61,167	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	37,164	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,969	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	82,194	0	0	0	69.01
69.02	03650	VASCULAR LAB	0.000000	7,140	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,616	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	308,660	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
91.00	09100	EMERGENCY	0.000000	3,772	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,416	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,168,486	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/23/2021 1:21 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	0.382338	0	2,266,419	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.034026	0	392,918	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.480109	0	912,619	0	0	54.00
54.01	03440	MAMMOGRAPHY	0.320820	0	162,046	0	0	54.01
56.00	05600	RADIOISOTOPE	0.259101	0	298,214	0	0	56.00
56.01	03630	ULTRA SOUND	0.268280	0	275,317	0	0	56.01
57.00	05700	CT SCAN	0.075760	0	3,209,569	1,263	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.232577	0	951,627	193	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.146354	0	4,946,595	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.345101	0	89,333	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.374952	0	313,206	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.423090	0	570,087	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.485871	0	98,040	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.466069	0	18,153	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.204411	0	858,375	0	0	69.01
69.02	03650	VASCULAR LAB	0.140066	0	246,708	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243441	0	340,835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300302	0	1,473,559	7,778	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
91.00	09100	EMERGENCY	0.408987	0	2,305,958	1,560	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.091350	0	156,720	0	0	92.00
200.00		Subtotal (see instructions)		0	19,886,298	10,794	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	19,886,298	10,794	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/23/2021 1:21 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	866,538	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	13,369	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	438,157	0		54.00
54.01	03440	MAMMOGRAPHY	51,988	0		54.01
56.00	05600	RADIOISOTOPE	77,268	0		56.00
56.01	03630	ULTRA SOUND	73,862	0		56.01
57.00	05700	CT SCAN	243,157	96		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	221,327	45		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	723,954	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,829	0		62.00
65.00	06500	RESPIRATORY THERAPY	117,437	0		65.00
66.00	06600	PHYSICAL THERAPY	241,198	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	47,635	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,461	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	175,461	0		69.01
69.02	03650	VASCULAR LAB	34,555	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,973	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	442,513	2,336		73.00
73.01	03480	ONCOLOGY	0	0		73.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100	EMERGENCY	943,107	638		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	484,476	0		92.00
200.00		Subtotal (see instructions)	5,318,265	3,115		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,318,265	3,115		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		496,229	0	496,229	1,216	408.08	30.00
31.00	INTENSIVE CARE UNIT		45,956		45,956	21	2,188.38	31.00
200.00	Total (lines 30 through 199)		542,185		542,185	1,237		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		8	3,265				
31.00	INTENSIVE CARE UNIT		3	6,565				
200.00	Total (lines 30 through 199)		11	9,830				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	315,048	0	0.000000	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	20,306	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	234,567	0	0.000000	0	0	54.00
54.01	03440 MAMMOGRAPHY	34,813	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	8,071	0	0.000000	0	0	56.00
56.01	03630 ULTRA SOUND	14,032	0	0.000000	0	0	56.01
57.00	05700 CT SCAN	106,397	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	288,064	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	163,281	0	0.000000	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4,918	0	0.000000	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	29,208	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	79,937	0	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	11,080	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	3,412	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160 CARDIOPULMONARY	63,211	0	0.000000	0	0	69.01
69.02	03650 VASCULAR LAB	3,647	0	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,477	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	81,080	0	0.000000	0	0	73.00
73.01	03480 ONCOLOGY	0	0	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	343,310	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	212,059	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	2,018,918	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-1325		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/23/2021 1:21 pm		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	1,216	0.00	8	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	21	0.00	3	31.00			
200.00		Total (lines 30 through 199)	0	0	1,237		11	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
31.00	03100	INTENSIVE CARE UNIT	0								31.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			Title XIX		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			Title XIX		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	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0.000000	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
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
54.01	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0.000000	0	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
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
69.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0.000000	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
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: 14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/23/2021 1:21 pm
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,693	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,216	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)		767	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		101	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)		304	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		18	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		54	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		443	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)		78	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)		233	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)		3,911,616	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		2,865	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		8,594	25.00
26.00	Total swing-bed cost (see instructions)		985,897	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,925,719	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,925,719	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)		2,406.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,065,867	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,065,867	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1325

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

Worksheet D-1

Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	168,052	21	8,002.48	11	88,027	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)					319,418	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,473,312	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)					187,670	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					560,603	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					748,273	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)					449	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,406.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,080,303	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1325		Period: From 10/01/2019 To 09/30/2020		Worksheet D-1 Date/Time Prepared: 4/23/2021 1:21 pm	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	496,229	3,911,616	0.126860	1,080,303	137,047	90.00
91.00	Nursing School cost	0	3,911,616	0.000000	1,080,303	0	91.00
92.00	Allied health cost	0	3,911,616	0.000000	1,080,303	0	92.00
93.00	All other Medical Education	0	3,911,616	0.000000	1,080,303	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/23/2021 1:21 pm	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		659,920		30.00
31.00	03100	INTENSIVE CARE UNIT		37,830		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.382338	126,446	48,345	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.034026	43,327	1,474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.480109	24,862	11,936	54.00
54.01	03440	MAMMOGRAPHY	0.320820	0	0	54.01
56.00	05600	RADIOISOTOPE	0.259101	3,201	829	56.00
56.01	03630	ULTRA SOUND	0.268280	1,864	500	56.01
57.00	05700	CT SCAN	0.075760	63,120	4,782	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.232577	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.146354	285,670	41,809	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.345101	19,497	6,728	62.00
65.00	06500	RESPIRATORY THERAPY	0.374952	84,401	31,646	65.00
66.00	06600	PHYSICAL THERAPY	0.423090	61,167	25,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.485871	37,164	18,057	67.00
68.00	06800	SPEECH PATHOLOGY	0.466069	7,969	3,714	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.204411	82,194	16,801	69.01
69.02	03650	VASCULAR LAB	0.140066	7,140	1,000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243441	4,616	1,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300302	308,660	92,691	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.408987	3,772	1,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.091350	3,416	10,560	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,168,486	319,418	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,168,486		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/23/2021 1:21 pm	
			Component CCN: 14-Z325			
			Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.382338	1,033	395	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.034026	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.480109	4,102	1,969	54.00
54.01	03440	MAMMOGRAPHY	0.320820	0	0	54.01
56.00	05600	RADIOISOTOPE	0.259101	0	0	56.00
56.01	03630	ULTRA SOUND	0.268280	0	0	56.01
57.00	05700	CT SCAN	0.075760	4,463	338	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.232577	3,333	775	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.146354	33,922	4,965	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.345101	1,775	613	62.00
65.00	06500	RESPIRATORY THERAPY	0.374952	17,339	6,501	65.00
66.00	06600	PHYSICAL THERAPY	0.423090	137,924	58,354	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.485871	99,642	48,413	67.00
68.00	06800	SPEECH PATHOLOGY	0.466069	3,944	1,838	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.204411	3,357	686	69.01
69.02	03650	VASCULAR LAB	0.140066	1,900	266	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243441	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300302	98,587	29,606	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.408987	223	91	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.091350	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		411,544	154,810	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)		411,544		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/23/2021 1:21 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,321,380 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)			5,321,380 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)			5,374,594 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			47,828 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,960,278 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,366,488 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,366,488 30.00
31.00	Primary payer payments			167 31.00
32.00	Subtotal (line 30 minus line 31)			2,366,321 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)			458,945 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			298,314 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			317,179 36.00
37.00	Subtotal (see instructions)			2,664,635 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,664,635 40.00
40.01	Sequestration adjustment (see instructions)			30,910 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			2,411,079 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)			222,646 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: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/23/2021 1:21 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,062,035		2,578,787	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/09/2020	8,761	09/09/2020	167,708	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)		-8,761		-167,708	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)		1,053,274		2,411,079	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		241,493		222,646	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,294,767		2,633,725	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:14-1325

Period:

Worksheet E-1

Component CCN:14-Z325

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/23/2021 1:21 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		752,849		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	09/09/2020	7,168		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		7,168		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)		760,017		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		136,912		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		896,929		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: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part II
Date/Time Prepared:
4/23/2021 1:21 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:14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet E-2
		Component CCN:14-Z325		Date/Time Prepared: 4/23/2021 1:21 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)		755,756	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)		156,358	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		311	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)		912,114	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		912,114	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)		912,114	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		4,659	0 13.00
14.00	80% of Part B costs (line 12 x 80%)			0 14.00
15.00	Subtotal (see instructions)		907,455	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)		907,455	0 19.00
19.01	Sequestration adjustment (see instructions)		10,526	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		760,017	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)		136,912	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: 14-1325	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 4/23/2021 1:21 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,473,312	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)		1,473,312	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,488,045	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)		1,488,045	19.00
20.00	Deductibles (exclude professional component)		197,648	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,290,397	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,290,397	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		30,102	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		19,566	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,346	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,309,963	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)		1,309,963	30.00
30.01	Sequestration adjustment (see instructions)		15,196	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,053,274	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)		241,493	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: 14-1325

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

Worksheet G

Date/Time Prepared:
4/23/2021 1:21 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	-734,681	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,060,393	0	0	0	4.00
5.00	Other receivable	233,193	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,113,983	0	0	0	6.00
7.00	Inventory	486,416	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,188,834	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,120,172	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,712,018	0	0	0	12.00
13.00	Land improvements	1,321,467	0	0	0	13.00
14.00	Accumulated depreciation	-949,835	0	0	0	14.00
15.00	Buildings	19,670,185	0	0	0	15.00
16.00	Accumulated depreciation	-12,933,492	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	15,993,954	0	0	0	23.00
24.00	Accumulated depreciation	-12,131,393	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	368,519	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,051,423	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	38,616,820	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	973,131	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	39,589,951	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58,761,546	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	826,537	0	0	0	37.00
38.00	Salaries, wages, and fees payable	94,928	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	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,403,582	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,325,047	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	29,538	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,538	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,354,585	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	54,406,961				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)	54,406,961	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,761,546	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1325

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

Worksheet G-1

Date/Time Prepared:
4/23/2021 1:21 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		46,946,099		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,761,398				2.00
3.00	Total (sum of line 1 and line 2)		54,707,497		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)		54,707,497		0		11.00
12.00	TRANSFERS	300,536		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)		300,536		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		54,406,961		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	TRANSFERS		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: 14-1325

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/23/2021 1:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,519,652		1,519,652	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	460,080		460,080	5.00
6.00	Swing bed - NF	81,792		81,792	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)	2,061,524		2,061,524	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	72,646		72,646	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)	72,646		72,646	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,134,170		2,134,170	17.00
18.00	Ancillary services	3,300,025	48,624,730	51,924,755	18.00
19.00	Outpatient services	211,800	9,180,813	9,392,613	19.00
20.00	RURAL HEALTH CLINIC	0	8,483,381	8,483,381	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	88,080	4,045,910	4,133,990	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,734,075	70,334,834	76,068,909	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,077,405		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,077,405		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1325

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

Worksheet G-3

Date/Time Prepared:
4/23/2021 1:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	76,068,909	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,987,890	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,081,019	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,077,405	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,003,614	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	283,080	6.00
7.00	Income from investments	2,078,286	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	77,401	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	2,809	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	525,112	24.00
24.01	340B REVENUE	1,577,298	24.01
24.50	COVID-19 PHE Funding	1,449,842	24.50
25.00	Total other income (sum of lines 6-24)	5,993,828	25.00
26.00	Total (line 5 plus line 25)	7,997,442	26.00
27.00	GAIN/LOSS ON DISPOSAL OF ASSETS	-9,824	27.00
27.01	EQUITY TRANSFER	245,868	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	236,044	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,761,398	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325

Period:

Worksheet M-1

Component CCN: 14-3445

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/23/2021 1:21 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	1,709,040	155,335	1,864,375	-189,240	1,675,135	1.00
2.00	Physician Assistant	255,282	0	255,282	-5,043	250,239	2.00
3.00	Nurse Practitioner	615,384	0	615,384	-5,945	609,439	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,228,787	0	1,228,787	-4,245	1,224,542	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	60,323	0	60,323	-205	60,118	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,868,816	155,335	4,024,151	-204,678	3,819,473	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	291,221	291,221	0	291,221	15.00
16.00	Transportation (Health Care Staff)	0	21,328	21,328	0	21,328	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	21,611	21,611	0	21,611	18.00
19.00	Other Health Care Costs	0	35,266	35,266	0	35,266	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	369,426	369,426	0	369,426	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,868,816	524,761	4,393,577	-204,678	4,188,899	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	24,560	24,560	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	24,560	24,560	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	131,967	131,967	-4,095	127,872	29.00
30.00	Administrative Costs	384,084	1,671,759	2,055,843	-866,766	1,189,077	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	384,084	1,803,726	2,187,810	-870,861	1,316,949	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,252,900	2,328,487	6,581,387	-1,050,979	5,530,408	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325

Period:

Worksheet M-1

Component CCN: 14-3445

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/23/2021 1:21 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	-129,570	1,545,565	1.00
2.00	Physician Assistant	0	250,239	2.00
3.00	Nurse Practitioner	181	609,620	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,224,542	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	60,118	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)	-129,389	3,690,084	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	291,221	15.00
16.00	Transportation (Health Care Staff)	0	21,328	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	21,611	18.00
19.00	Other Health Care Costs	0	35,266	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	369,426	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-129,389	4,059,510	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	24,560	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	24,560	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	127,872	29.00
30.00	Administrative Costs	-135,979	1,053,098	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-135,979	1,180,970	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-265,368	5,265,040	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1325

Period:

Worksheet M-2

Component CCN: 14-3445

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/23/2021 1:21 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	3.99	11,811	2,940	11,731		1.00
2.00	Physician Assistant	0.95	5,140	2,100	1,995		2.00
3.00	Nurse Practitioner	4.06	9,569	2,100	8,526		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.00	26,520		22,252	26,520	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.76	715			715	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)	9.76	27,235			27,235	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)					4,059,510	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					24,560	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,084,070	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.993986	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,180,970	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,700,916	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,881,886	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,881,886	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,852,526	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,912,036	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1325 Component CCN: 14-3445	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/23/2021 1:21 pm		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			8,912,036	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			289,959	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			8,622,077	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			27,235	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)			27,235	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			316.58	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)			316.58	316.58	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	6,388	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	2,022,313	11.00	
12.00	Program covered visits for mental health services (from contractor records)		0	94	12.00	
13.00	Program covered cost from mental health services (line 9 x line 12)		0	29,759	13.00	
14.00	Limit adjustment for mental health services (see instructions)		0	29,759	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	2,052,072	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			1,609,849	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			8,935	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			11,389	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.)			1,526,982	16.04	
16.05	Total program cost (see instructions)		0	1,538,371	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			131,956	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			293,742	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			1,538,371	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			83,305	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,621,676	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)			1,621,676	26.00	
26.01	Sequestration adjustment (see instructions)			18,811	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			1,263,494	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)			339,371	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: 14-1325 Component CCN: 14-3445	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/23/2021 1:21 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)		3,690,084	3,690,084	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000915	0.003150	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,376	11,624	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		86,918	30,159	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		90,294	41,783	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		4,059,510	4,059,510	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,852,526	4,852,526	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.022243	0.010293	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		107,935	49,947	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		198,229	91,730	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		591	2,035	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		335.41	45.08	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		177	531	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		59,368	23,937	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)			289,959	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)			83,305	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1325 Component CCN:14-3445	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/23/2021 1:21 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		1,378,097	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50		09/09/2020	114,603	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)		-114,603	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,263,494	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		339,371	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,602,865	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	2.00		
8.00	Name of Contractor			8.00	