

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/25/2022 1:11 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/25/2022	Time: 1:11 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF HOLY FAMILY MED CTR (14-1318) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

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	-225,723	-716,365	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	-419,647	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		290,396		0	10.00
10.01	ROSEVILLE RHC II	0		26,481		0	10.01
200.00	Total	0	-645,370	-399,488	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1318		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/25/2022 1:11 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1000 WEST HARLEM AVENUE			PO Box:				1.00	
2.00	City: MONMOUTH			State: IL		Zip Code: 61462		County: WARREN	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			OSF HOLY FAMILY MED CTR	141318	99914	1	05/01/2002	N
4.00	Subprovider - IPF							O	P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			OSF HOLY FAMILY SWING BEDS	142318	99914		05/01/2002	N
8.00	Swing Beds - NF							O	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			OSF HOLY FAMILY CLINICS	143461	99914		02/05/2003	N
15.01	Hospital-Based Health Clinic - RHC II			OSF ROSEVILLE RHC	148621	99914		02/18/2021	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)						10/01/2020	09/30/2021	
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	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	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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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		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/25/2022 1:11 pm	
				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	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
<u>Miscellaneous Cost Reporting Information</u>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	5,292	0	14,730	118.01		
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N			120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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	
<u>Transplant Center Information</u>							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/25/2022 1:11 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: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:				142.00	
143.00	City: PEORIA	State: IL		Zip Code: 61603		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/25/2022 1:11 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1318		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part II Date/Time Prepared: 2/25/2022 1:11 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? 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 programs 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	12/14/2021	Y	12/14/2021		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/25/2022 1:11 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/25/2022 1:11 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 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	19	7,179	15,328.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		19	7,179	15,328.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		19	7,179	15,328.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 ROSEVILLE RHC	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		19				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/25/2022 1:11 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)	343	4	571		1.00
2.00	HMO and other (see instructions)	90	59			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	541	0	810		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		19	131		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	884	23	1,512		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)	884	23	1,512	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	5,225	4,561	20,056	0.00	39.13
26.01	ROSEVILLE RHC	926	244	2,386	0.00	2.96
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	139.15
28.00	Observation Bed Days		42	268		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/25/2022 1:11 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	117	1	203	1.00
2.00 HMO and other (see instructions)			27	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	117	1	203	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 ROSEVILLE RHC	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1318 Component CCN: 14-3461		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/25/2022 1:11 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1000 W. HARLEM			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			MONMOUTH			IL 61462		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:00			18:00		07:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N			12.00		
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N			0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number						14.00		
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00		
				County		4.00			
2.00	City, State, ZIP Code, County			WARREN			2.00		
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC			18:00			07:00		18:00

Health Financial Systems		OSF HOLY FAMILY MED CTR		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1318	Period: From 10/01/2020	Worksheet S-8
			Component CCN: 14-3461	To 09/30/2021	Date/Time Prepared: 2/25/2022 1:11 pm
			RHC I		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
Facility hours of operations (1)					to
11.00	CLINIC		07:00	18:00	08:00
					17:00
					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1318 Component CCN: 14-8621		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/25/2022 1:11 pm		
				RHC II		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				235 PENN AVENUE			1.00		
				City		State		ZIP Code		
				1.00		2.00		3.00		
2.00	City, State, ZIP Code, County				ROSEVILLE IL 61473			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				07:00		17:00		07:15	
						1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number								14.00	
				Y/N		V		Total Visits		
				1.00		2.00		3.00 4.00 5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00	
				County						
				4.00						
2.00	City, State, ZIP Code, County				WARREN				2.00	
				Tuesday		Wednesday		Thursday		
				to		from to		from to		
				6.00		7.00 8.00		9.00 10.00		
Facility hours of operations (1)										
11.00	CLINIC				11:15		07:00		17:00	
						07:00		17:00		

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1318 Component CCN: 14-8621		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/25/2022 1:11 pm	
						RHC II		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			07:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/25/2022 1:11 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)		0.326496		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		5,015,512		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		15,331,234		6.00
7.00	Medicaid cost (line 1 times line 6)		5,005,587		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0		9.00
10.00	Stand-alone CHIP charges		0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,482,246	459,187	1,941,433	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	483,947	459,187	943,134	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)	483,947	459,187	943,134	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,308,914		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		66,775		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		102,731		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,206,183		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		429,770		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,372,904		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,372,904		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/25/2022 1:11 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		837,000	837,000	292,916	1,129,916 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		281,840	281,840	456,491	738,331 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	194,349	267,934	462,283	2,870,984	3,333,267 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	937,314	6,001,792	6,939,106	-907,824	6,031,282 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	613,244	613,244	-509,888	103,356 6.00
7.00	00700	OPERATION OF PLANT	215,169	976,886	1,192,055	-200,050	992,005 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	67,606	67,606 8.00
9.00	00900	HOUSEKEEPING	363,383	290,225	653,608	-208,301	445,307 9.00
10.00	01000	DIETARY	265,363	242,636	507,999	-108,122	399,877 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	84,173	25,459	109,632	59,094	168,726 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,939	16,071	49,010	-10,986	38,024 16.00
17.00	01700	SOCIAL SERVICE	0	108	108	243,117	243,225 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	923,920	752,322	1,676,242	-238,064	1,438,178 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	344,184	521,229	865,413	-471,290	394,123 50.00
53.00	05300	ANESTHESIOLOGY	117,020	35,184	152,204	-22,667	129,537 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	580,230	315,517	895,747	197,563	1,093,310 54.00
56.00	05600	RADIOISOTOPE	31,257	34,794	66,051	-5,682	60,369 56.00
57.00	05700	CT SCAN	0	54,969	54,969	-52,545	2,424 57.00
58.00	05800	MRI	0	222,906	222,906	-2,331	220,575 58.00
60.00	06000	LABORATORY	493,638	794,887	1,288,525	-154,390	1,134,135 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	151,364	73,021	224,385	-66,378	158,007 65.00
66.00	06600	PHYSICAL THERAPY	326,733	103,028	429,761	-75,794	353,967 66.00
67.00	06700	OCCUPATIONAL THERAPY	92,797	18,785	111,582	-9,623	101,959 67.00
68.00	06800	SPEECH PATHOLOGY	10,589	2,503	13,092	-1,442	11,650 68.00
69.00	06900	ELECTROCARDIOLOGY	159,554	52,232	211,786	-46,324	165,462 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-22,218	-22,218	419,165	396,947 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	84,146	84,146 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	229,290	1,394,255	1,623,545	-25,821	1,597,724 73.00
76.00	03950	DIABETIC SERVICES	53,066	23,431	76,497	-19,299	57,198 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,074,611	2,292,795	5,367,406	-1,137,474	4,229,932 88.00
88.01	08801	ROSEVILLE RHC	366,905	217,068	583,973	-107,634	476,339 88.01
91.00	09100	EMERGENCY	1,088,771	2,895,878	3,984,649	-351,152	3,633,497 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,136,619	19,335,781	29,472,400	-41,999	29,430,401 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	42,027	42,027 192.00
194.00	07950	NONREIMBURSABLE COST CENTER	233	-49	184	-28	156 194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,136,852	19,335,732	29,472,584	0	29,472,584 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/25/2022 1:11 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	365,900	1,495,816	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	172,713	911,044	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	896,174	4,229,441	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-454,613	5,576,669	5.00
6.00	00600	MAINTENANCE & REPAIRS	4,906	108,262	6.00
7.00	00700	OPERATION OF PLANT	0	992,005	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,606	8.00
9.00	00900	HOUSEKEEPING	0	445,307	9.00
10.00	01000	DIETARY	0	399,877	10.00
11.00	01100	CAFETERIA	-37,876	-37,876	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	295,964	464,690	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,467	36,557	16.00
17.00	01700	SOCIAL SERVICE	-37,153	206,072	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-459,467	978,711	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-810	393,313	50.00
53.00	05300	ANESTHESIOLOGY	-118,284	11,253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,964	1,116,274	54.00
56.00	05600	RADIOISOTOPE	0	60,369	56.00
57.00	05700	CT SCAN	0	2,424	57.00
58.00	05800	MRI	0	220,575	58.00
60.00	06000	LABORATORY	1,608	1,135,743	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	158,007	65.00
66.00	06600	PHYSICAL THERAPY	0	353,967	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	101,959	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,650	68.00
69.00	06900	ELECTROCARDIOLOGY	0	165,462	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	396,947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	84,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-487,312	1,110,412	73.00
76.00	03950	DIABETIC SERVICES	-1,450	55,748	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-253,031	3,976,901	88.00
88.01	08801	ROSEVILLE RHC	-19,743	456,596	88.01
91.00	09100	EMERGENCY	-1,885,526	1,747,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,996,503	27,433,898	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	42,027	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	156	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,996,503	27,476,081	200.00

RECLASSIFICATIONS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet A-6
Date/Time Prepared:
2/25/2022 1:11 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MAINTENANCE COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	476,086		1.00
2.00	LABORATORY	60.00	0	33,802		2.00
	0		0	509,888		
	B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	422,191		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,435		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	430,626		
	F - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	23,844		1.00
	0		0	23,844		
	G - EMPLOYEE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,897,745		1.00
2.00	SOCIAL SERVICE	17.00	0	1		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	0		0	2,897,746		
	I - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	276,765		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	448,798		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	0		0	725,563		
	J - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	67,606		1.00
	0		0	67,606		

RECLASSIFICATIONS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	84,146		1.00
2.00		0.00	0	0		2.00
	0		0	84,146		
	M - MINISTRY ALLOCATION RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	274,997		1.00
2.00	OPERATION OF PLANT	7.00	0	51,678		2.00
3.00	SOCIAL SERVICE	17.00	0	243,116		3.00
4.00	PHYSICAL THERAPY	66.00	0	16,568		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	4,302		5.00
6.00	SPEECH PATHOLOGY	68.00	0	505		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	35,093		7.00
	0		0	626,259		
	N - PHYSICIAN NON-RHC VISITS					
1.00	ADULTS & PEDIATRICS	30.00	59,955	0		1.00
	0		59,955	0		
	O - VP CHIEF NURSING OFFICER					
1.00	NURSING ADMINISTRATION	13.00	81,666	0		1.00
	0		81,666	0		
	P - REHAB ADMINISTRATION					
1.00	OCCUPATIONAL THERAPY	67.00	396	3,276		1.00
2.00	SPEECH PATHOLOGY	68.00	48	394		2.00
	TOTALS		444	3,670		
	Q - ROSEVILLE NON-RHC					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	31,319	10,708		1.00
	TOTALS		31,319	10,708		
	R - VACATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	10,126	0		1.00
2.00	OPERATION OF PLANT	7.00	2,324	0		2.00
3.00	HOUSEKEEPING	9.00	3,926	0		3.00
4.00	DIETARY	10.00	2,867	0		4.00
5.00	NURSING ADMINISTRATION	13.00	909	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	356	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	9,981	0		7.00
8.00	OPERATING ROOM	50.00	3,718	0		8.00
9.00	ANESTHESIOLOGY	53.00	1,264	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	6,268	0		10.00
11.00	RADIOISOTOPE	56.00	338	0		11.00
12.00	LABORATORY	60.00	5,333	0		12.00
13.00	RESPIRATORY THERAPY	65.00	1,635	0		13.00
14.00	PHYSICAL THERAPY	66.00	3,530	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	1,002	0		15.00
16.00	SPEECH PATHOLOGY	68.00	114	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	1,724	0		17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	2,477	0		18.00
19.00	DIABETIC SERVICES	76.00	573	0		19.00
20.00	RURAL HEALTH CLINIC	88.00	33,215	0		20.00
21.00	ROSEVILLE RHC	88.01	3,964	0		21.00
22.00	EMERGENCY	91.00	11,762	0		22.00
23.00	NONREIMBURSABLE COST CENTER	194.00	3	0		23.00
	TOTALS		107,409	0		
	S - NON PHYS BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	87,875	0		1.00
2.00	HOUSEKEEPING	9.00	9,000	0		2.00
3.00	DIETARY	10.00	4,725	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	8,625	0		4.00
5.00	OPERATING ROOM	50.00	3,000	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	16,198	0		6.00
7.00	RADIOISOTOPE	56.00	375	0		7.00
8.00	LABORATORY	60.00	6,975	0		8.00
9.00	RESPIRATORY THERAPY	65.00	1,500	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	2,250	0		10.00
11.00	DIABETIC SERVICES	76.00	750	0		11.00
12.00	RURAL HEALTH CLINIC	88.00	34,102	0		12.00
13.00	EMERGENCY	91.00	18,974	0		13.00
	TOTALS		194,349	0		
	T - RHC PROVIDER RECLASS					
1.00	ROSEVILLE RHC	88.01	12,968	0		1.00
	TOTALS		12,968	0		
500.00	Grand Total: Increases		488,110	5,380,056		500.00

RECLASSIFICATIONS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MAINTENANCE COSTS						
1.00	MAINTENANCE & REPAIRS	6.00	0	509,888	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	509,888			
	B - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	33,732	0		1.00
2.00	OPERATING ROOM	50.00	0	208,167	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	4,696	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,487	0		4.00
5.00	RADIOISOTOPE	56.00	0	616	0		5.00
6.00	CT SCAN	57.00	0	34,023	0		6.00
7.00	MRI	58.00	0	2,331	0		7.00
8.00	LABORATORY	60.00	0	28,923	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	9,186	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	4,121	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	314	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	1,779	0		12.00
13.00	DIABETIC SERVICES	76.00	0	792	0		13.00
14.00	EMERGENCY	91.00	0	76,459	0		14.00
	0		0	430,626			
	F - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,844	12		1.00
	0		0	23,844			
	G - EMPLOYEE BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	257,270	0		1.00
2.00	OPERATION OF PLANT	7.00	0	52,986	0		2.00
3.00	HOUSEKEEPING	9.00	0	152,391	0		3.00
4.00	DIETARY	10.00	0	102,884	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	23,481	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	11,342	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	245,904	0		7.00
8.00	OPERATING ROOM	50.00	0	100,367	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	16,308	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	182,915	0		10.00
11.00	RADIOISOTOPE	56.00	0	2,456	0		11.00
12.00	LABORATORY	60.00	0	152,835	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	55,433	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	83,487	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	18,285	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	2,503	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	44,351	0		17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	54,249	0		18.00
19.00	DIABETIC SERVICES	76.00	0	19,830	0		19.00
20.00	RURAL HEALTH CLINIC	88.00	0	979,919	0		20.00
21.00	ROSEVILLE RHC	88.01	0	81,638	0		21.00
22.00	EMERGENCY	91.00	0	256,881	0		22.00
23.00	NONREIMBURSABLE COST CENTER	194.00	0	31	0		23.00
	0		0	2,897,746			
	I - DEPRECIATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,986	9		1.00
2.00	OPERATION OF PLANT	7.00	0	201,066	9		2.00
3.00	HOUSEKEEPING	9.00	0	1,230	0		3.00
4.00	DIETARY	10.00	0	12,830	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	36,989	0		5.00
6.00	OPERATING ROOM	50.00	0	87,128	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	2,927	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	92,587	0		8.00
9.00	RADIOISOTOPE	56.00	0	3,323	0		9.00
10.00	CT SCAN	57.00	0	18,522	0		10.00
11.00	LABORATORY	60.00	0	18,742	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	4,894	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	4,170	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	4,168	0		14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,026	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,577	0		16.00
17.00	RURAL HEALTH CLINIC	88.00	0	151,949	0		17.00
18.00	ROSEVILLE RHC	88.01	0	901	0		18.00
19.00	EMERGENCY	91.00	0	48,548	0		19.00
	0		0	725,563			
	J - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	0	67,606	0		1.00
	0		0	67,606			

RECLASSIFICATIONS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	82,346	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,800	0		2.00
	0		0	84,146			
	M - MINISTRY ALLOCATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	626,259	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	626,259			
	N - PHYSICIAN NON-RHC VISITS						
1.00	RURAL HEALTH CLINIC	88.00	59,955	0	0		1.00
	0		59,955	0			
	O - VP CHIEF NURSING OFFICER						
1.00	ADMINISTRATIVE & GENERAL	5.00	81,666	0	0		1.00
	0		81,666	0			
	P - REHAB ADMINISTRATION						
1.00	PHYSICAL THERAPY	66.00	444	3,670	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		444	3,670			
	Q - ROSEVILLE NON-RHC						
1.00	ROSEVILLE RHC	88.01	31,319	10,708	0		1.00
	TOTALS		31,319	10,708			
	R - VACATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	107,409	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
	TOTALS		0	107,409			
	S - NON PHYS BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	194,349	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	TOTALS		194,349	0			
	T - RHC PROVIDER RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	12,968	0	0		1.00
	TOTALS		12,968	0			
500.00	Grand Total: Decreases		380,701	5,487,465			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	325,000	0	0	0	0	1.00
2.00	Land Improvements	369,733	0	0	0	0	2.00
3.00	Buildings and Fixtures	20,616,681	14,095	0	14,095	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,936,601	1,221,141	0	1,221,141	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,248,015	1,235,236	0	1,235,236	0	8.00
9.00	Reconciling Items	420,721	701,652	0	701,652	0	9.00
10.00	Total (line 8 minus line 9)	29,827,294	533,584	0	533,584	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	325,000	0				1.00
2.00	Land Improvements	369,733	0				2.00
3.00	Buildings and Fixtures	20,630,776	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	10,157,742	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	31,483,251	0				8.00
9.00	Reconciling Items	1,122,373	0				9.00
10.00	Total (line 8 minus line 9)	30,360,878	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/25/2022 1:11 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	837,000	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	281,840	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,118,840	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	837,000				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	281,840				2.00
3.00	Total (sum of lines 1-2)	0	1,118,840				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,325,509	0	21,325,509	0.677360	16,151	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,157,742	0	10,157,742	0.322640	7,693	2.00
3.00	Total (sum of lines 1-2)	31,483,251	0	31,483,251	1.000000	23,844	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	16,151	1,479,665	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	7,693	903,351	0	2.00
3.00	Total (sum of lines 1-2)	0	0	23,844	2,383,016	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	16,151	0	0	1,495,816	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,693	0	0	911,044	2.00
3.00	Total (sum of lines 1-2)	0	23,844	0	0	2,406,860	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-239	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,575	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,438,850			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	651,111			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-37,876	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,467	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-29,207	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	307,131	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	128,696	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/25/2022 1:11 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 #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING	A	-11,928	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	SHARED ED BENEFITS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	LASALA - ER BENEFITS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	WIECHERT - ER BENEFITS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	PROVIDER TAX IDPA	A	-946,517	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC. INCOME	B	-161	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MISC. INCOME	B	-1,450	DIABETIC SERVICES	76.00	0	33.06
33.07	GRANT EXPENSES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	340B EXPENSE	A	-489,141	DRUGS CHARGED TO PATIENTS	73.00	0	33.08
33.09	CRNA BENEFITS	A	-16,496	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	UNEMPLOYMENT COMP	A	898,304	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	HOSPITALIST & IP PALLIATIVE CARE	A	0	ADULTS & PEDIATRICS	30.00	0	33.11
33.12	DR. LEONARD RHC SALARY EXPENSE	A	0	RURAL HEALTH CLINIC	88.00	0	33.12
33.13	DR. LEONARD RHC BENEFIT EXPENSE	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	NON-RHC VISITS PA SALARY EXPENSE	A	0	RURAL HEALTH CLINIC	88.00	0	33.14
33.15	NON-RHC VISIT PA & PHYSICIAN BENEFIT	A	-25,066	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	DEFINED BENEFIT PENSION	A	39,432	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	MEDICAL DIRECTOR FEE	A	-13,200	RURAL HEALTH CLINIC	88.00	0	33.17
33.18	RHC MISC INCOME	A	-4	ROSEVILLE RHC	88.01	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,996,503				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/25/2022 1:11 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	72,553	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	299,454	255,437	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO POOLED - ADMIN & GENERAL	2,088,079	2,821,279	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	274,997	274,997	3.01
3.02	6.00	MAINTENANCE & REPAIRS	MINISTRY ALLOCATION	57	57	3.02
3.03	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	51,678	51,678	3.03
3.04	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	16,568	16,568	3.04
3.05	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	4,302	4,302	3.05
3.06	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	505	505	3.06
3.07	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	91,621	91,621	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	266	266	3.08
3.09	60.00	LABORATORY	MINISTRY ALLOCATION	19	19	3.09
4.00	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	295,964	0	4.00
4.01	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	205,963	243,116	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO FUNCTIONAL - ADMIN & GEN	2,128,358	852,144	4.02
4.03	73.00	DRUGS CHARGED TO PATIENTS		1,829	0	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	SFI EQUIPMENT RENTAL	810	517	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	SFI CVO	39,251	39,251	4.05
4.06	6.00	MAINTENANCE & REPAIRS	SFI HEALTHCARE TECHNOLOGY SV	103,029	98,123	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	SFI HEALTHCARE TECHNOLOGY SV	476,102	453,431	4.07
4.08	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	33,771	32,163	4.08
4.09	30.00	ADULTS & PEDIATRICS	OSFMG-MINISTRY	0	21,187	4.09
4.10	91.00	EMERGENCY	OSFMG-MINISTRY	0	4,050	4.10
4.11	88.00	RURAL HEALTH CLINIC	OSFMG-MINISTRY	0	239,831	4.11
4.12	88.01	ROSEVILLE RHC	OSFMG-MINISTRY	0	19,739	4.12
4.13	1.00	CAP REL COSTS-BLDG & FIXT	OSFMG-MINISTRY	0	13,784	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,185,176	5,534,065	5.00

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

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

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

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

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

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

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

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

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

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/25/2022 1:11 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	72,553	9		1.00
2.00	44,017	9		2.00
3.00	-733,200	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
4.00	295,964	0		4.00
4.01	-37,153	0		4.01
4.02	1,276,214	0		4.02
4.03	1,829	0		4.03
4.04	293	0		4.04
4.05	0	0		4.05
4.06	4,906	0		4.06
4.07	22,671	0		4.07
4.08	1,608	0		4.08
4.09	-21,187	0		4.09
4.10	-4,050	0		4.10
4.11	-239,831	0		4.11
4.12	-19,739	0		4.12
4.13	-13,784	9		4.13
5.00	651,111			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/25/2022 1:11 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	438,280	438,280	0	0	0	1.00
2.00	50.00	OPERATING ROOM	810	810	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	127,735	118,284	9,451	0	0	3.00
4.00	60.00	LABORATORY	15,600	0	15,600	0	0	4.00
5.00	91.00	EMERGENCY	2,469,129	1,881,476	587,653	0	0	5.00
6.00	91.00	EMERGENCY	56,436	0	56,436	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			3,107,990	2,438,850	669,140		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	438,280		1.00
2.00	50.00	OPERATING ROOM	0	0	0	810		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	118,284		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	1,881,476		5.00
6.00	91.00	EMERGENCY	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	2,438,850		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/25/2022 1:11 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	1,495,816	1,495,816			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	911,044		911,044		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,229,441	0	0	4,229,441	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,576,669	227,092	138,313	400,727	5.00
6.00	00600	MAINTENANCE & REPAIRS	108,262	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	992,005	172,132	104,839	91,391	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,606	0	0	0	8.00
9.00	00900	HOUSEKEEPING	445,307	17,868	10,883	158,127	9.00
10.00	01000	DIETARY	399,877	102,874	62,656	114,697	10.00
11.00	01100	CAFETERIA	-37,876	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	464,600	0	0	70,068	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,557	19,755	12,032	13,991	16.00
17.00	01700	SOCIAL SERVICE	206,072	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	978,711	158,458	96,511	396,053	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	393,313	87,235	53,132	147,110	50.00
53.00	05300	ANESTHESIOLOGY	11,253	3,602	2,194	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,116,274	78,239	47,652	253,255	54.00
56.00	05600	RADIOISOTOPE	60,369	0	0	13,434	56.00
57.00	05700	CT SCAN	2,424	0	0	0	57.00
58.00	05800	MRI	220,575	0	0	0	58.00
60.00	06000	LABORATORY	1,135,743	29,624	18,043	212,601	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	158,007	0	0	64,921	65.00
66.00	06600	PHYSICAL THERAPY	353,967	69,243	42,173	138,591	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,959	4,381	2,668	39,581	67.00
68.00	06800	SPEECH PATHOLOGY	11,650	546	332	4,518	68.00
69.00	06900	ELECTROCARDIOLOGY	165,462	27,098	16,505	68,715	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	396,947	50,112	30,521	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,146	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,110,412	17,322	10,550	97,389	73.00
76.00	03950	DIABETIC SERVICES	55,748	19,162	11,671	22,854	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,976,901	244,242	148,758	1,289,609	88.00
88.01	08801	ROSEVILLE RHC	456,596	30,653	18,670	148,129	88.01
91.00	09100	EMERGENCY	1,747,971	93,176	56,750	470,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,433,898	1,452,814	884,853	4,216,182	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	42,027	43,002	26,191	13,160	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	156	0	0	99	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,476,081	1,495,816	911,044	4,229,441	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1318

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,342,801					5.00
6.00	00600	MAINTENANCE & REPAIRS	32,435	140,697				6.00
7.00	00700	OPERATION OF PLANT	407,561	19,985	1,787,913			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,254	0	0	87,860		8.00
9.00	00900	HOUSEKEEPING	189,400	2,109	29,133	0	852,827	9.00
10.00	01000	DIETARY	203,756	11,944	167,728	0	81,331	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	160,211	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,667	3,141	32,208	0	15,618	16.00
17.00	01700	SOCIAL SERVICE	61,738	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	488,261	18,607	258,354	29,526	125,275	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	203,962	10,293	142,231	9,517	68,967	50.00
53.00	05300	ANESTHESIOLOGY	5,108	418	5,872	0	2,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	448,022	9,084	127,563	16,746	61,855	54.00
56.00	05600	RADIOISOTOPE	22,111	0	0	0	0	56.00
57.00	05700	CT SCAN	726	0	0	0	0	57.00
58.00	05800	MRI	66,083	0	0	0	0	58.00
60.00	06000	LABORATORY	418,239	3,439	48,300	347	23,421	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	66,788	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	180,948	8,039	112,895	6,533	54,742	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,517	509	7,143	0	3,464	67.00
68.00	06800	SPEECH PATHOLOGY	5,107	63	890	0	431	68.00
69.00	06900	ELECTROCARDIOLOGY	83,222	3,007	44,182	1,137	21,424	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	143,081	6,386	81,703	0	39,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,210	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	370,203	2,011	28,243	0	13,695	73.00
76.00	03950	DIABETIC SERVICES	32,786	2,225	31,242	0	15,149	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,695,576	28,357	398,221	1,004	193,095	88.00
88.01	08801	ROSEVILLE RHC	195,950	0	49,978	0	24,234	88.01
91.00	09100	EMERGENCY	709,539	11,080	151,916	21,841	73,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,305,461	140,697	1,717,802	86,651	818,830	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	37,264	0	70,111	1,209	33,997	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	76	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)	6,342,801	140,697	1,787,913	87,860	852,827	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,144,863					10.00
11.00	01100	CAFETERIA	729,029	691,153				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	10,425	0	705,394		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,706	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	277,029	88,975	0	320,955	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	127,086	32,204	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,652	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,369	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	2,523	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	58,896	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	14,874	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25,298	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,640	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	930	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,268	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,733	0	60,410	0	73.00
76.00	03950	DIABETIC SERVICES	0	4,847	0	17,466	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	259,822	0	0	0	88.00
88.01	08801	ROSEVILLE RHC	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	11,719	84,991	0	306,563	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,144,863	691,153	0	705,394	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	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)	1,144,863	691,153	0	705,394	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	164,675				16.00
17.00	01700	SOCIAL SERVICE	0	0	267,810			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,971	267,810	3,511,496	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,495	0	1,288,545	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,310	0	38,256	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,917	0	2,228,976	0	54.00
56.00	05600	RADIOISOTOPE	0	1,678	0	100,115	0	56.00
57.00	05700	CT SCAN	0	18,616	0	21,766	0	57.00
58.00	05800	MRI	0	4,818	0	291,476	0	58.00
60.00	06000	LABORATORY	0	31,790	0	1,980,443	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,283	0	305,873	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,070	0	997,499	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,421	0	212,283	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	204	0	24,671	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,324	0	454,344	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,259	0	749,627	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,403	0	110,759	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,563	0	1,744,531	0	73.00
76.00	03950	DIABETIC SERVICES	0	82	0	213,232	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	13,217	0	8,248,802	0	88.00
88.01	08801	ROSEVILLE RHC	0	1,331	0	925,541	0	88.01
91.00	09100	EMERGENCY	0	20,923	0	3,760,554	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	164,675	267,810	27,208,789	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	266,961	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0	0	331	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	164,675	267,810	27,476,081	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	ROSEVILLE RHC	88.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,268	227,092	138,313	368,673	0 5.00
6.00	00600	MAINTENANCE & REPAIRS	1,208	0	0	1,208	0 6.00
7.00	00700	OPERATION OF PLANT	0	172,132	104,839	276,971	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	0	17,868	10,883	28,751	0 9.00
10.00	01000	DIETARY	0	102,874	62,656	165,530	0 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,755	12,032	31,787	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	158,458	96,511	254,969	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	87,235	53,132	140,367	0 50.00
53.00	05300	ANESTHESIOLOGY	0	3,602	2,194	5,796	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,106	78,239	47,652	126,997	0 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	29,624	18,043	47,667	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	69,243	42,173	111,416	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,381	2,668	7,049	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	546	332	878	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,098	16,505	43,603	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,112	30,521	80,633	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	17,322	10,550	27,872	0 73.00
76.00	03950	DIABETIC SERVICES	0	19,162	11,671	30,833	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	244,242	148,758	393,000	0 88.00
88.01	08801	ROSEVILLE RHC	0	30,653	18,670	49,323	0 88.01
91.00	09100	EMERGENCY	0	93,176	56,750	149,926	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,582	1,452,814	884,853	2,343,249	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	43,002	26,191	69,193	0 192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0	0	0	0 194.00
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	5,582	1,495,816	911,044	2,412,442	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	368,673					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,885	3,093				6.00
7.00	00700	OPERATION OF PLANT	23,689	439	301,099			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,177	0	0	1,177		8.00
9.00	00900	HOUSEKEEPING	11,009	46	4,906	0	44,712	9.00
10.00	01000	DIETARY	11,843	263	28,247	0	4,264	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	9,312	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,434	69	5,424	0	819	16.00
17.00	01700	SOCIAL SERVICE	3,589	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,380	409	43,509	396	6,568	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,855	226	23,953	127	3,616	50.00
53.00	05300	ANESTHESIOLOGY	297	9	989	0	149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,041	200	21,483	224	3,243	54.00
56.00	05600	RADIOISOTOPE	1,285	0	0	0	0	56.00
57.00	05700	CT SCAN	42	0	0	0	0	57.00
58.00	05800	MRI	3,841	0	0	0	0	58.00
60.00	06000	LABORATORY	24,310	76	8,134	5	1,228	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,882	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,518	177	19,012	88	2,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,588	11	1,203	0	182	67.00
68.00	06800	SPEECH PATHOLOGY	297	1	150	0	23	68.00
69.00	06900	ELECTROCARDIOLOGY	4,837	66	7,441	15	1,123	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,317	140	13,759	0	2,077	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,465	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,518	44	4,756	0	718	73.00
76.00	03950	DIABETIC SERVICES	1,906	49	5,261	0	794	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	98,554	624	67,064	13	10,123	88.00
88.01	08801	ROSEVILLE RHC	11,390	0	8,417	0	1,271	88.01
91.00	09100	EMERGENCY	41,242	244	25,584	293	3,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	366,503	3,093	289,292	1,161	42,930	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,166	0	11,807	16	1,782	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	4	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)	368,673	3,093	301,099	1,177	44,712	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	210,147					10.00
11.00	01100	CAFETERIA	133,818	126,865				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,914	0	11,226		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,231	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	50,850	16,332	0	5,108	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,328	5,911	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	670	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,530	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	463	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	10,811	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,730	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,644	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,219	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	171	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,986	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,071	0	961	0	73.00
76.00	03950	DIABETIC SERVICES	0	890	0	278	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	47,691	0	0	0	88.00
88.01	08801	ROSEVILLE RHC	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	2,151	15,601	0	4,879	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	210,147	126,865	0	11,226	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	6,953	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	210,147	133,818	0	11,226	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,764				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,589			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,725	3,589	411,835	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,340	0	212,723	0	50.00
53.00	05300	ANESTHESIOLOGY	0	819	0	8,729	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,197	0	191,915	0	54.00
56.00	05600	RADIOISOTOPE	0	415	0	2,163	0	56.00
57.00	05700	CT SCAN	0	4,607	0	4,649	0	57.00
58.00	05800	MRI	0	1,192	0	5,033	0	58.00
60.00	06000	LABORATORY	0	7,878	0	100,109	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	318	0	6,930	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,255	0	149,980	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	352	0	12,604	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	50	0	1,570	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,813	0	61,884	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	312	0	105,238	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	347	0	1,812	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,346	0	63,286	0	73.00
76.00	03950	DIABETIC SERVICES	0	20	0	40,031	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,271	0	620,340	0	88.00
88.01	08801	ROSEVILLE RHC	0	329	0	70,730	0	88.01
91.00	09100	EMERGENCY	0	5,178	0	248,960	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	40,764	3,589	2,320,521	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	84,964	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0	0	4	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	6,953	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	40,764	3,589	2,412,442	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	DIABETIC SERVICES	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	ROSEVILLE RHC	88.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MOVABLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	95,937					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		95,937				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,065,212			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,565	14,565	953,649	-6,342,801	21,171,156	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	108,262	6.00
7.00	00700	OPERATION OF PLANT	11,040	11,040	217,493	0	1,360,367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	67,606	8.00
9.00	00900	HOUSEKEEPING	1,146	1,146	376,309	0	632,185	9.00
10.00	01000	DIETARY	6,598	6,598	272,955	0	680,104	10.00
11.00	01100	CAFETERIA	0	0	0	37,876	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	166,748	0	534,758	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,267	1,267	33,295	0	82,335	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	206,072	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,163	10,163	942,526	0	1,629,733	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,595	5,595	350,092	0	680,790	50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	0	17,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	602,696	0	1,495,420	54.00
56.00	05600	RADIOISOTOPE	0	0	31,970	0	73,803	56.00
57.00	05700	CT SCAN	0	0	0	0	2,424	57.00
58.00	05800	MRI	0	0	0	0	220,575	58.00
60.00	06000	LABORATORY	1,900	1,900	505,946	0	1,396,011	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	154,499	0	222,928	65.00
66.00	06600	PHYSICAL THERAPY	4,441	4,441	329,819	0	603,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	94,195	0	148,589	67.00
68.00	06800	SPEECH PATHOLOGY	35	35	10,751	0	17,046	68.00
69.00	06900	ELECTROCARDIOLOGY	1,738	1,738	163,528	0	277,780	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,214	3,214	0	0	477,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	84,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	231,767	0	1,235,673	73.00
76.00	03950	DIABETIC SERVICES	1,229	1,229	54,389	0	109,435	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,665	15,665	3,069,005	0	5,659,510	88.00
88.01	08801	ROSEVILLE RHC	1,966	1,966	352,518	0	654,048	88.01
91.00	09100	EMERGENCY	5,976	5,976	1,119,507	0	2,368,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,179	93,179	10,033,657	-6,304,925	21,046,521	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,758	2,758	31,319	0	124,380	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0	236	0	255	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)	1,495,816	911,044	4,229,441		6,342,801	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.591649	9.496274	0.420204		0.299596	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		368,673	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.017414	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	77,724				6.00
7.00	00700	OPERATION OF PLANT	11,040	70,332			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	87,038		8.00
9.00	00900	HOUSEKEEPING	1,165	1,146	0	69,186	9.00
10.00	01000	DIETARY	6,598	6,598	0	6,598	29,503 10.00
11.00	01100	CAFETERIA	0	0	0	0	18,787 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,735	1,267	0	1,267	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,279	10,163	29,249	10,163	7,139 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,686	5,595	9,428	5,595	3,275 50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	231	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	16,589	5,018	0 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	1,900	1,900	344	1,900	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	4,441	4,441	6,472	4,441	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	0	281	0 67.00
68.00	06800	SPEECH PATHOLOGY	35	35	0	35	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,661	1,738	1,126	1,738	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,528	3,214	0	3,214	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	0	1,111	0 73.00
76.00	03950	DIABETIC SERVICES	1,229	1,229	0	1,229	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	15,665	15,665	995	15,665	0 88.00
88.01	08801	ROSEVILLE RHC	0	1,966	0	1,966	0 88.01
91.00	09100	EMERGENCY	6,121	5,976	21,637	5,976	302 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,724	67,574	85,840	66,428	29,503 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,758	1,198	2,758	0 192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	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)	140,697	1,787,913	87,860	852,827	1,144,863 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.810213	25.421046	1.009444	12.326583	38.804969 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,093	301,099	1,177	44,712	210,147 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.039795	4.281110	0.013523	0.646258	7.122903 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	10,409					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	157	0	61,268			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,340	0	27,877	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	485	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	55	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	864	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	38	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	887	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	224	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	381	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	245	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	252	0	5,247	0	0	73.00
76.00	03950	DIABETIC SERVICES	73	0	1,517	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,913	0	0	0	0	88.00
88.01	08801	ROSEVILLE RHC	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	1,280	0	26,627	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,409	0	61,268	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	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)	691,153	0	705,394	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	66.399558	0.000000	11.513253	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	133,818	0	11,226	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.188010	0.000000	0.183228	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,335,862	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,527,598	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	6,829,528	50.00
53.00	05300	ANESTHESIOLOGY	1,674,869	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,536,900	54.00
56.00	05600	RADIOISOTOPE	848,973	56.00
57.00	05700	CT SCAN	9,421,016	57.00
58.00	05800	MRI	2,438,395	58.00
60.00	06000	LABORATORY	16,086,730	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	649,398	65.00
66.00	06600	PHYSICAL THERAPY	2,565,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	718,950	67.00
68.00	06800	SPEECH PATHOLOGY	103,067	68.00
69.00	06900	ELECTROCARDIOLOGY	3,706,701	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	637,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	710,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,887,963	73.00
76.00	03950	DIABETIC SERVICES	41,532	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	6,688,657	88.00
88.01	08801	ROSEVILLE RHC	673,757	88.01
91.00	09100	EMERGENCY	10,588,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,335,862	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	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)	164,675	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001976	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,764	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000489	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,511,496		3,511,496	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,288,545		1,288,545	0
53.00	05300	ANESTHESIOLOGY	38,256		38,256	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,228,976		2,228,976	0
56.00	05600	RADIOISOTOPE	100,115		100,115	0
57.00	05700	CT SCAN	21,766		21,766	0
58.00	05800	MRI	291,476		291,476	0
60.00	06000	LABORATORY	1,980,443		1,980,443	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	305,873	0	305,873	0
66.00	06600	PHYSICAL THERAPY	997,499	0	997,499	0
67.00	06700	OCCUPATIONAL THERAPY	212,283	0	212,283	0
68.00	06800	SPEECH PATHOLOGY	24,671	0	24,671	0
69.00	06900	ELECTROCARDIOLOGY	454,344		454,344	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	749,627		749,627	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,759		110,759	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,744,531		1,744,531	0
76.00	03950	DIABETIC SERVICES	213,232		213,232	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,248,802		8,248,802	0
88.01	08801	ROSEVILLE RHC	925,541		925,541	0
91.00	09100	EMERGENCY	3,760,554		3,760,554	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	566,895		566,895	0
200.00		Subtotal (see instructions)	27,775,684	0	27,775,684	0
201.00		Less Observation Beds	566,895		566,895	0
202.00		Total (see instructions)	27,208,789	0	27,208,789	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/25/2022 1:11 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	2,899,224		2,899,224		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,983	6,751,545	6,829,528	0.188673	0.000000
53.00	05300	ANESTHESIOLOGY	21,781	1,653,088	1,674,869	0.022841	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,699	6,412,201	6,536,900	0.340984	0.000000
56.00	05600	RADIOISOTOPE	2,578	846,395	848,973	0.117925	0.000000
57.00	05700	CT SCAN	262,818	9,158,198	9,421,016	0.002310	0.000000
58.00	05800	MRI	49,384	2,389,011	2,438,395	0.119536	0.000000
60.00	06000	LABORATORY	836,441	15,250,289	16,086,730	0.123110	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	352,313	297,085	649,398	0.471010	0.000000
66.00	06600	PHYSICAL THERAPY	367,995	2,197,774	2,565,769	0.388772	0.000000
67.00	06700	OCCUPATIONAL THERAPY	185,561	533,389	718,950	0.295268	0.000000
68.00	06800	SPEECH PATHOLOGY	22,301	80,766	103,067	0.239369	0.000000
69.00	06900	ELECTROCARDIOLOGY	84,108	3,622,593	3,706,701	0.122574	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,242	595,128	637,370	1.176125	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	710,005	710,005	0.155997	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,416,329	7,471,634	8,887,963	0.196280	0.000000
76.00	03950	DIABETIC SERVICES	4,494	37,038	41,532	5.134162	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,688,657	6,688,657		88.00
88.01	08801	ROSEVILLE RHC	0	673,757	673,757		88.01
91.00	09100	EMERGENCY	203,924	10,384,760	10,588,684	0.355148	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	97,167	531,207	628,374	0.902162	0.000000
200.00		Subtotal (see instructions)	7,051,342	76,284,520	83,335,862		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	7,051,342	76,284,520	83,335,862		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	DIABETIC SERVICES	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	ROSEVILLE RHC				88.01
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
1.00			2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,511,496		3,511,496	0	3,511,496	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,288,545		1,288,545	0	1,288,545	50.00
53.00	05300	ANESTHESIOLOGY	38,256		38,256	0	38,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,228,976		2,228,976	0	2,228,976	54.00
56.00	05600	RADIOISOTOPE	100,115		100,115	0	100,115	56.00
57.00	05700	CT SCAN	21,766		21,766	0	21,766	57.00
58.00	05800	MRI	291,476		291,476	0	291,476	58.00
60.00	06000	LABORATORY	1,980,443		1,980,443	0	1,980,443	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	305,873	0	305,873	0	305,873	65.00
66.00	06600	PHYSICAL THERAPY	997,499	0	997,499	0	997,499	66.00
67.00	06700	OCCUPATIONAL THERAPY	212,283	0	212,283	0	212,283	67.00
68.00	06800	SPEECH PATHOLOGY	24,671	0	24,671	0	24,671	68.00
69.00	06900	ELECTROCARDIOLOGY	454,344		454,344	0	454,344	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	749,627		749,627	0	749,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,759		110,759	0	110,759	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,744,531		1,744,531	0	1,744,531	73.00
76.00	03950	DIABETIC SERVICES	213,232		213,232	0	213,232	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,248,802		8,248,802	0	8,248,802	88.00
88.01	08801	ROSEVILLE RHC	925,541		925,541	0	925,541	88.01
91.00	09100	EMERGENCY	3,760,554		3,760,554	0	3,760,554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	566,895		566,895	0	566,895	92.00
200.00		Subtotal (see instructions)	27,775,684	0	27,775,684	0	27,775,684	200.00
201.00		Less Observation Beds	566,895		566,895	0	566,895	201.00
202.00		Total (see instructions)	27,208,789	0	27,208,789	0	27,208,789	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

			Title XIX		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,899,224		2,899,224			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,983	6,751,545	6,829,528	0.188673	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	21,781	1,653,088	1,674,869	0.022841	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,699	6,412,201	6,536,900	0.340984	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,578	846,395	848,973	0.117925	0.000000	56.00
57.00	05700	CT SCAN	262,818	9,158,198	9,421,016	0.002310	0.000000	57.00
58.00	05800	MRI	49,384	2,389,011	2,438,395	0.119536	0.000000	58.00
60.00	06000	LABORATORY	836,441	15,250,289	16,086,730	0.123110	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	352,313	297,085	649,398	0.471010	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	367,995	2,197,774	2,565,769	0.388772	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	185,561	533,389	718,950	0.295268	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,301	80,766	103,067	0.239369	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	84,108	3,622,593	3,706,701	0.122574	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,242	595,128	637,370	1.176125	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	710,005	710,005	0.155997	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,416,329	7,471,634	8,887,963	0.196280	0.000000	73.00
76.00	03950	DIABETIC SERVICES	4,494	37,038	41,532	5.134162	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,688,657	6,688,657	1.233252	0.000000	88.00
88.01	08801	ROSEVILLE RHC	0	673,757	673,757	1.373701	0.000000	88.01
91.00	09100	EMERGENCY	203,924	10,384,760	10,588,684	0.355148	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	97,167	531,207	628,374	0.902162	0.000000	92.00
200.00		Subtotal (see instructions)	7,051,342	76,284,520	83,335,862			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,051,342	76,284,520	83,335,862			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.188673			50.00
53.00	05300	ANESTHESIOLOGY	0.022841			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.340984			54.00
56.00	05600	RADIOISOTOPE	0.117925			56.00
57.00	05700	CT SCAN	0.002310			57.00
58.00	05800	MRI	0.119536			58.00
60.00	06000	LABORATORY	0.123110			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.471010			65.00
66.00	06600	PHYSICAL THERAPY	0.388772			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295268			67.00
68.00	06800	SPEECH PATHOLOGY	0.239369			68.00
69.00	06900	ELECTROCARDIOLOGY	0.122574			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.176125			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.155997			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196280			73.00
76.00	03950	DIABETIC SERVICES	5.134162			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.233252			88.00
88.01	08801	ROSEVILLE RHC	1.373701			88.01
91.00	09100	EMERGENCY	0.355148			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.902162			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part II
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,288,545	212,723	1,075,822	0	0
53.00	05300	ANESTHESIOLOGY	38,256	8,729	29,527	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,228,976	191,915	2,037,061	0	0
56.00	05600	RADIOISOTOPE	100,115	2,163	97,952	0	0
57.00	05700	CT SCAN	21,766	4,649	17,117	0	0
58.00	05800	MRI	291,476	5,033	286,443	0	0
60.00	06000	LABORATORY	1,980,443	100,109	1,880,334	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	305,873	6,930	298,943	0	0
66.00	06600	PHYSICAL THERAPY	997,499	149,980	847,519	0	0
67.00	06700	OCCUPATIONAL THERAPY	212,283	12,604	199,679	0	0
68.00	06800	SPEECH PATHOLOGY	24,671	1,570	23,101	0	0
69.00	06900	ELECTROCARDIOLOGY	454,344	61,884	392,460	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	749,627	105,238	644,389	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,759	1,812	108,947	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,744,531	63,286	1,681,245	0	0
76.00	03950	DIABETIC SERVICES	213,232	40,031	173,201	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,248,802	620,340	7,628,462	0	0
88.01	08801	ROSEVILLE RHC	925,541	70,730	854,811	0	0
91.00	09100	EMERGENCY	3,760,554	248,960	3,511,594	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	566,895	66,487	500,408	0	0
200.00		Subtotal (sum of lines 50 thru 199)	24,264,188	1,975,173	22,289,015	0	0
201.00		Less Observation Beds	566,895	66,487	500,408	0	0
202.00		Total (line 200 minus line 201)	23,697,293	1,908,686	21,788,607	0	0

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

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part II
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Title XIX		Hospital	PPS
			Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,288,545	6,829,528	0.188673	50.00
53.00	05300	ANESTHESIOLOGY	38,256	1,674,869	0.022841	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,228,976	6,536,900	0.340984	54.00
56.00	05600	RADIOISOTOPE	100,115	848,973	0.117925	56.00
57.00	05700	CT SCAN	21,766	9,421,016	0.002310	57.00
58.00	05800	MRI	291,476	2,438,395	0.119536	58.00
60.00	06000	LABORATORY	1,980,443	16,086,730	0.123110	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	305,873	649,398	0.471010	65.00
66.00	06600	PHYSICAL THERAPY	997,499	2,565,769	0.388772	66.00
67.00	06700	OCCUPATIONAL THERAPY	212,283	718,950	0.295268	67.00
68.00	06800	SPEECH PATHOLOGY	24,671	103,067	0.239369	68.00
69.00	06900	ELECTROCARDIOLOGY	454,344	3,706,701	0.122574	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	749,627	637,370	1.176125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,759	710,005	0.155997	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,744,531	8,887,963	0.196280	73.00
76.00	03950	DIABETIC SERVICES	213,232	41,532	5.134162	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,248,802	6,688,657	1.233252	88.00
88.01	08801	ROSEVILLE RHC	925,541	673,757	1.373701	88.01
91.00	09100	EMERGENCY	3,760,554	10,588,684	0.355148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	566,895	628,374	0.902162	92.00
200.00		Subtotal (sum of lines 50 thru 199)	24,264,188	80,436,638		200.00
201.00		Less Observation Beds	566,895	0		201.00
202.00		Total (line 200 minus line 201)	23,697,293	80,436,638		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/25/2022 1:11 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	212,723	6,829,528	0.031148	17,594	548	50.00
53.00	05300 ANESTHESIOLOGY	8,729	1,674,869	0.005212	5,705	30	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	191,915	6,536,900	0.029359	35,721	1,049	54.00
56.00	05600 RADIOISOTOPE	2,163	848,973	0.002548	2,578	7	56.00
57.00	05700 CT SCAN	4,649	9,421,016	0.000493	37,910	19	57.00
58.00	05800 MRI	5,033	2,438,395	0.002064	14,243	29	58.00
60.00	06000 LABORATORY	100,109	16,086,730	0.006223	232,612	1,448	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	6,930	649,398	0.010671	128,311	1,369	65.00
66.00	06600 PHYSICAL THERAPY	149,980	2,565,769	0.058454	26,418	1,544	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,604	718,950	0.017531	19,335	339	67.00
68.00	06800 SPEECH PATHOLOGY	1,570	103,067	0.015233	8,808	134	68.00
69.00	06900 ELECTROCARDIOLOGY	61,884	3,706,701	0.016695	44,690	746	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105,238	637,370	0.165113	20,175	3,331	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,812	710,005	0.002552	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63,286	8,887,963	0.007120	336,697	2,397	73.00
76.00	03950 DIABETIC SERVICES	40,031	41,532	0.963859	3,424	3,300	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	620,340	6,688,657	0.092745	0	0	88.00
88.01	08801 ROSEVILLE RHC	70,730	673,757	0.104979	0	0	88.01
91.00	09100 EMERGENCY	248,960	10,588,684	0.023512	14,121	332	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	66,487	628,374	0.105808	0	0	92.00
200.00	Total (lines 50 through 199)	1,975,173	80,436,638		948,342	16,622	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	DIABETIC SERVICES	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	ROSEVILLE RHC	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 1:11 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	6,829,528	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	1,674,869	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,536,900	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	848,973	0.000000
57.00	05700	CT SCAN	0	0	0	9,421,016	0.000000
58.00	05800	MRI	0	0	0	2,438,395	0.000000
60.00	06000	LABORATORY	0	0	0	16,086,730	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	649,398	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,565,769	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	718,950	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	103,067	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,706,701	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	637,370	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	710,005	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,887,963	0.000000
76.00	03950	DIABETIC SERVICES	0	0	0	41,532	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,688,657	0.000000
88.01	08801	ROSEVILLE RHC	0	0	0	673,757	0.000000
91.00	09100	EMERGENCY	0	0	0	10,588,684	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	628,374	0.000000
200.00		Total (lines 50 through 199)	0	0	0	80,436,638	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 1:11 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	17,594	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	5,705	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	35,721	0	0	0 54.00
56.00	05600	RADIOISOTOPE	0.000000	2,578	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	37,910	0	0	0 57.00
58.00	05800	MRI	0.000000	14,243	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	232,612	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	128,311	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	26,418	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	19,335	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	8,808	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	44,690	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	20,175	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	336,697	0	0	0 73.00
76.00	03950	DIABETIC SERVICES	0.000000	3,424	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
88.01	08801	ROSEVILLE RHC	0.000000	0	0	0	0 88.01
91.00	09100	EMERGENCY	0.000000	14,121	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)		948,342	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/25/2022 1:11 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	0.188673	0	2,311,453	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.022841	0	537,813	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.340984	0	1,874,255	0	0	54.00
56.00	05600	RADIOISOTOPE	0.117925	0	297,322	0	0	56.00
57.00	05700	CT SCAN	0.002310	0	3,127,235	0	0	57.00
58.00	05800	MRI	0.119536	0	668,590	0	0	58.00
60.00	06000	LABORATORY	0.123110	0	5,235,054	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.471010	0	119,147	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.388772	0	620,785	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295268	0	107,437	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.239369	0	28,984	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.122574	0	1,492,019	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.176125	0	162,582	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.155997	0	257,923	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196280	0	3,503,934	1,353	0	73.00
76.00	03950	DIABETIC SERVICES	5.134162	0	13,781	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	ROSEVILLE RHC						88.01
91.00	09100	EMERGENCY	0.355148	0	4,480,576	624	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.902162	0	221,212	0	0	92.00
200.00		Subtotal (see instructions)		0	25,060,102	1,977	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	25,060,102	1,977	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/25/2022 1:11 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	436,109	0		50.00
53.00	05300	ANESTHESIOLOGY	12,284	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	639,091	0		54.00
56.00	05600	RADIOISOTOPE	35,062	0		56.00
57.00	05700	CT SCAN	7,224	0		57.00
58.00	05800	MRI	79,921	0		58.00
60.00	06000	LABORATORY	644,487	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	56,119	0		65.00
66.00	06600	PHYSICAL THERAPY	241,344	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	31,723	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,938	0		68.00
69.00	06900	ELECTROCARDIOLOGY	182,883	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	191,217	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,235	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	687,752	266		73.00
76.00	03950	DIABETIC SERVICES	70,754	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	ROSEVILLE RHC				88.01
91.00	09100	EMERGENCY	1,591,268	222		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	199,569	0		92.00
200.00		Subtotal (see instructions)	5,153,980	488		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,153,980	488		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/25/2022 1:11 pm

			Title XIX		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	411,835	203,692	208,143	839	248.08	30.00	
200.00	Total (lines 30 through 199)	411,835		208,143	839		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	4	992					30.00
200.00	Total (lines 30 through 199)	4	992					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XIX		Hospital Program Charges	PPS	
			Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)		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	212,723	6,829,528	0.031148	3,137	98	50.00
53.00	05300 ANESTHESIOLOGY	8,729	1,674,869	0.005212	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	191,915	6,536,900	0.029359	6,246	183	54.00
56.00	05600 RADIOISOTOPE	2,163	848,973	0.002548	0	0	56.00
57.00	05700 CT SCAN	4,649	9,421,016	0.000493	51,074	25	57.00
58.00	05800 MRI	5,033	2,438,395	0.002064	0	0	58.00
60.00	06000 LABORATORY	100,109	16,086,730	0.006223	72,101	449	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	6,930	649,398	0.010671	14,238	152	65.00
66.00	06600 PHYSICAL THERAPY	149,980	2,565,769	0.058454	2,584	151	66.00
67.00	06700 OCCUPATIONAL THERAPY	12,604	718,950	0.017531	745	13	67.00
68.00	06800 SPEECH PATHOLOGY	1,570	103,067	0.015233	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	61,884	3,706,701	0.016695	3,094	52	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105,238	637,370	0.165113	2,308	381	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,812	710,005	0.002552	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63,286	8,887,963	0.007120	95,317	679	73.00
76.00	03950 DIABETIC SERVICES	40,031	41,532	0.963859	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	620,340	6,688,657	0.092745	0	0	88.00
88.01	08801 ROSEVILLE RHC	70,730	673,757	0.104979	0	0	88.01
91.00	09100 EMERGENCY	248,960	10,588,684	0.023512	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	66,487	628,374	0.105808	1,355	143	92.00
200.00	Total (lines 50 through 199)	1,975,173	80,436,638		252,199	2,326	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-1318		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/25/2022 1:11 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	839	0.00	4	30.00			
200.00		Total (lines 30 through 199)	0	0	839		4	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	ROSEVILLE RHC	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description			Title XIX		Hospital	PPS	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	6,829,528	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	1,674,869	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,536,900	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	848,973	0.000000
57.00	05700	CT SCAN	0	0	0	9,421,016	0.000000
58.00	05800	MRI	0	0	0	2,438,395	0.000000
60.00	06000	LABORATORY	0	0	0	16,086,730	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	649,398	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,565,769	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	718,950	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	103,067	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,706,701	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	637,370	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	710,005	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,887,963	0.000000
76.00	03950	DIABETIC SERVICES	0	0	0	41,532	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,688,657	0.000000
88.01	08801	ROSEVILLE RHC	0	0	0	673,757	0.000000
91.00	09100	EMERGENCY	0	0	0	10,588,684	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	628,374	0.000000
200.00		Total (lines 50 through 199)	0	0	0	80,436,638	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 1:11 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	3,137	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,246	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	51,074	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	72,101	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	14,238	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,584	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	745	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,094	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,308	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	95,317	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	ROSEVILLE RHC	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,355	0	0	0	92.00
200.00		Total (lines 50 through 199)		252,199	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/25/2022 1:11 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,780	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		839	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)		571	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		203	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)		607	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		33	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)		98	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		343	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)		135	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)		406	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		178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		178.59	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,511,496	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)		5,893	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)		17,502	25.00
26.00	Total swing-bed cost (see instructions)		1,736,772	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,774,724	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,774,724	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)		2,115.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		725,541	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)		725,541	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					242,773	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					968,314	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)					285,563	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					858,804	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,144,367	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)					268	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,115.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					566,895	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/25/2022 1:11 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	411,835	3,511,496	0.117282	566,895	66,487
91.00	Nursing Program cost	0	3,511,496	0.000000	566,895	0
92.00	Allied health cost	0	3,511,496	0.000000	566,895	0
93.00	All other Medical Education	0	3,511,496	0.000000	566,895	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/25/2022 1:11 pm	
		Title XIX	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,780	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			839	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)			571	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			203	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)			607	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			33	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)			98	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			4	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			19	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			178.59	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			178.59	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,511,496	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)			5,893	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)			17,502	25.00
26.00	Total swing-bed cost (see instructions)			1,736,772	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,774,724	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,774,724	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)			2,115.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			8,461	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)			8,461	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					42,671	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					51,132	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)					992	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,326	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,318	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					47,814	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					3,393	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					3,393	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)					268	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,115.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					566,895	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1318		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/25/2022 1:11 pm		
				Title XIX		Hospital		PPS		
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)				
		1.00	2.00	3.00	4.00	5.00				
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	411,835	3,511,496	0.117282	566,895	66,487	90.00			
91.00	Nursing Program cost	0	3,511,496	0.000000	566,895	0	91.00			
92.00	Allied health cost	0	3,511,496	0.000000	566,895	0	92.00			
93.00	All other Medical Education	0	3,511,496	0.000000	566,895	0	93.00			

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/25/2022 1:11 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		631,635		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.188673	17,594	3,320	50.00
53.00	05300 ANESTHESIOLOGY	0.022841	5,705	130	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.340984	35,721	12,180	54.00
56.00	05600 RADIOISOTOPE	0.117925	2,578	304	56.00
57.00	05700 CT SCAN	0.002310	37,910	88	57.00
58.00	05800 MRI	0.119536	14,243	1,703	58.00
60.00	06000 LABORATORY	0.123110	232,612	28,637	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.471010	128,311	60,436	65.00
66.00	06600 PHYSICAL THERAPY	0.388772	26,418	10,271	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.295268	19,335	5,709	67.00
68.00	06800 SPEECH PATHOLOGY	0.239369	8,808	2,108	68.00
69.00	06900 ELECTROCARDIOLOGY	0.122574	44,690	5,478	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.176125	20,175	23,728	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.155997	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.196280	336,697	66,087	73.00
76.00	03950 DIABETIC SERVICES	5.134162	3,424	17,579	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 ROSEVILLE RHC	0.000000		0	88.01
91.00	09100 EMERGENCY	0.355148	14,121	5,015	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.902162	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		948,342	242,773	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		948,342		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318 Component CCN: 14-Z318	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/25/2022 1:11 pm	
		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				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.188673	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.022841	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.340984	19,992	6,817	54.00
56.00	05600 RADIOISOTOPE	0.117925	0	0	56.00
57.00	05700 CT SCAN	0.002310	28,897	67	57.00
58.00	05800 MRI	0.119536	15,952	1,907	58.00
60.00	06000 LABORATORY	0.123110	158,403	19,501	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.471010	97,390	45,872	65.00
66.00	06600 PHYSICAL THERAPY	0.388772	193,889	75,379	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.295268	90,708	26,783	67.00
68.00	06800 SPEECH PATHOLOGY	0.239369	6,847	1,639	68.00
69.00	06900 ELECTROCARDIOLOGY	0.122574	2,652	325	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.176125	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.155997	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.196280	321,142	63,034	73.00
76.00	03950 DIABETIC SERVICES	5.134162	1,070	5,494	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 ROSEVILLE RHC	0.000000		0	88.01
91.00	09100 EMERGENCY	0.355148	6,574	2,335	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.902162	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		943,516	249,153	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		943,516		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/25/2022 1:11 pm	
		Title XIX	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		93,961		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.188673	3,137	592	50.00
53.00	05300 ANESTHESIOLOGY	0.022841	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.340984	6,246	2,130	54.00
56.00	05600 RADIOISOTOPE	0.117925	0	0	56.00
57.00	05700 CT SCAN	0.002310	51,074	118	57.00
58.00	05800 MRI	0.119536	0	0	58.00
60.00	06000 LABORATORY	0.123110	72,101	8,876	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.471010	14,238	6,706	65.00
66.00	06600 PHYSICAL THERAPY	0.388772	2,584	1,005	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.295268	745	220	67.00
68.00	06800 SPEECH PATHOLOGY	0.239369	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.122574	3,094	379	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.176125	2,308	2,714	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.155997	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.196280	95,317	18,709	73.00
76.00	03950 DIABETIC SERVICES	5.134162	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.233252	0	0	88.00
88.01	08801 ROSEVILLE RHC	1.373701	0	0	88.01
91.00	09100 EMERGENCY	0.355148	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.902162	1,355	1,222	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		252,199	42,671	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		252,199	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/25/2022 1:11 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,154,468 1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)			0 2.00
3.00	OPPI 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)			5,154,468 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)			5,206,013 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)			36,024 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			3,696,414 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			1,473,575 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,473,575 30.00
31.00	Primary payer payments			199 31.00
32.00	Subtotal (line 30 minus line 31)			1,473,376 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)			81,079 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			52,701 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			81,079 36.00
37.00	Subtotal (see instructions)			1,526,077 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			1,526,077 40.00
40.01	Sequestration adjustment (see instructions)			0 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			2,242,442 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)			-716,365 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			86,804 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/25/2022 1:11 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		1,040,261		1,896,142	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/21/2021	44,814	05/21/2021	261,671	3.01
3.02		08/17/2021	5,663	08/17/2021	84,629	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)		50,477		346,300	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)		1,090,738		2,242,442	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		225,723		716,365	6.02
7.00	Total Medicare program liability (see instructions)		865,015		1,526,077	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1318

Period:

Worksheet E-1

Component CCN: 14-Z318

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/25/2022 1:11 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,706,652		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/21/2021	92,330		0	3.01
3.02		08/17/2021	17,733		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)		110,063		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,816,715		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		419,647		0	6.02
7.00	Total Medicare program liability (see instructions)		1,397,068		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 2/25/2022 1:11 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 through 12, and 32.			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 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet E-2	
		Component CCN: 14-Z318		Date/Time Prepared: 2/25/2022 1:11 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,155,811	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)		251,645	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		541	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,407,456	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,407,456	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,407,456	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		10,388	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,397,068	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,397,068	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		1,816,715	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, 19.02, 19.25, 20, and 21)		-419,647	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1318	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/25/2022 1:11 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		968,314	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)		968,314	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		977,997	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)		977,997	19.00
20.00	Deductibles (exclude professional component)		127,056	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		850,941	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		850,941	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		21,652	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		14,074	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		21,652	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		865,015	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		865,015	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		1,090,738	31.00
31.01	Interim payments-PARHM			31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)			32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-225,723	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		5,314	34.00

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

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/25/2022 1:11 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,673	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,827,748	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,895,822	0	0	0	6.00
7.00	Inventory	283,482	0	0	0	7.00
8.00	Prepaid expenses	2,788	0	0	0	8.00
9.00	Other current assets	56,236	0	0	0	9.00
10.00	Due from other funds	26,093	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,302,198	0	0	0	11.00
FIXED ASSETS						
12.00	Land	325,000	0	0	0	12.00
13.00	Land improvements	369,733	0	0	0	13.00
14.00	Accumulated depreciation	-303,417	0	0	0	14.00
15.00	Buildings	20,630,776	0	0	0	15.00
16.00	Accumulated depreciation	-7,048,512	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	9,035,369	0	0	0	23.00
24.00	Accumulated depreciation	-5,570,076	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	1,122,373	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,561,246	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	48,886,593	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,631,798	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	55,518,391	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	79,381,835	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,066,765	0	0	0	37.00
38.00	Salaries, wages, and fees payable	237,781	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	3,050,119	0	0	0	43.00
44.00	Other current liabilities	318,721	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,673,386	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	1,156,511	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,156,511	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,829,897	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	73,551,938				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)	73,551,938	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	79,381,835	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
2/25/2022 1:11 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		57,763,471		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,057,690				2.00
3.00	Total (sum of line 1 and line 2)		70,821,161		0		3.00
4.00	EQUITY TRANSFER	2,730,777		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)		2,730,777		0		10.00
11.00	Subtotal (line 3 plus line 10)		73,551,938		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		73,551,938		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	EQUITY TRANSFER		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/25/2022 1:11 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	107,078		107,078	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,403,441		2,403,441	5.00
6.00	Swing bed - NF	388,705		388,705	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)	2,899,224		2,899,224	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,899,224		2,899,224	17.00
18.00	Ancillary services	3,851,027	58,006,139	61,857,166	18.00
19.00	Outpatient services	301,091	10,915,967	11,217,058	19.00
20.00	RURAL HEALTH CLINIC	0	6,688,657	6,688,657	20.00
20.01	ROSEVILLE RHC	0	673,757	673,757	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	60,208	4,373,533	4,433,741	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,111,550	80,658,053	87,769,603	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,472,584		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,472,584		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1318

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-3

Date/Time Prepared:
2/25/2022 1:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	87,769,603	1.00
2.00	Less contractual allowances and discounts on patients' accounts	50,003,277	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,766,326	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,472,584	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,293,742	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	32,664	6.00
7.00	Income from investments	24,963	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	12,501	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	37,876	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	1,134,830	17.00
18.00	Revenue from sale of medical records and abstracts	1,467	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	4,517	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	419,225	24.00
24.50	COVID-19 PHE Funding	3,095,905	24.50
25.00	Total other income (sum of lines 6-24)	4,763,948	25.00
26.00	Total (line 5 plus line 25)	13,057,690	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,057,690	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period:

Worksheet M-1

Component CCN: 14-3461

From 10/01/2020

To 09/30/2021

Date/Time Prepared:
2/25/2022 1:11 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	752,972	0	752,972	-52,497	700,475
2.00	Physician Assistant	371,413	0	371,413	-6,268	365,145
3.00	Nurse Practitioner	386,479	0	386,479	-15,584	370,895
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	1,137,606	0	1,137,606	5,905	1,143,511
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	139,895	0	139,895	-14,886	125,009
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	2,788,365	0	2,788,365	-83,330	2,705,035
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	30,948	30,948	0	30,948
14.00	Subtotal (sum of lines 11 through 13)	0	30,948	30,948	0	30,948
15.00	Medical Supplies	0	252,393	252,393	0	252,393
16.00	Transportation (Health Care Staff)	0	2,836	2,836	0	2,836
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	12,581	12,581	0	12,581
19.00	Other Health Care Costs	0	5,373	5,373	0	5,373
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	273,183	273,183	0	273,183
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,788,365	304,131	3,092,496	-83,330	3,009,166
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	71,457	71,457
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	71,457	71,457
FACILITY OVERHEAD						
29.00	Facility Costs	0	158,093	158,093	-151,949	6,144
30.00	Administrative Costs	286,246	1,830,571	2,116,817	-973,652	1,143,165
31.00	Total Facility Overhead (sum of lines 29 and 30)	286,246	1,988,664	2,274,910	-1,125,601	1,149,309
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,074,611	2,292,795	5,367,406	-1,137,474	4,229,932

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period:

Worksheet M-1

Component CCN: 14-3461

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 1:11 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	-13,200	687,275	1.00
2.00	Physician Assistant	0	365,145	2.00
3.00	Nurse Practitioner	0	370,895	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,143,511	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	125,009	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)	-13,200	2,691,835	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	30,948	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	30,948	14.00
15.00	Medical Supplies	0	252,393	15.00
16.00	Transportation (Health Care Staff)	0	2,836	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	12,581	18.00
19.00	Other Health Care Costs	0	5,373	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	273,183	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-13,200	2,995,966	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	71,457	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	71,457	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	6,144	29.00
30.00	Administrative Costs	-239,831	903,334	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-239,831	909,478	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-253,031	3,976,901	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period:

Worksheet M-1

Component CCN: 14-8621

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 1:11 pm

		RHC II		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	217,465	0	217,465	-18,544	198,921
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	23,739	0	23,739	9,656	33,395
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	91,543	0	91,543	-7,639	83,904
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	332,747	0	332,747	-16,527	316,220
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	13,360	13,360	-67	13,293
16.00	Transportation (Health Care Staff)	0	1,960	1,960	0	1,960
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	2,760	2,760	0	2,760
19.00	Other Health Care Costs	0	887	887	0	887
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	18,967	18,967	-67	18,900
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	332,747	18,967	351,714	-16,594	335,120
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	4,685	4,685
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	4,685	4,685
FACILITY OVERHEAD						
29.00	Facility Costs	0	16,288	16,288	-965	15,323
30.00	Administrative Costs	34,159	181,813	215,972	-94,761	121,211
31.00	Total Facility Overhead (sum of lines 29 and 30)	34,159	198,101	232,260	-95,726	136,534
32.00	Total facility costs (sum of lines 22, 28 and 31)	366,906	217,068	583,974	-107,635	476,339

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318

Period:

Worksheet M-1

Component CCN: 14-8621

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/25/2022 1:11 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	198,921	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	33,395	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	83,904	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	316,220	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	13,293	15.00
16.00	Transportation (Health Care Staff)	0	1,960	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	2,760	18.00
19.00	Other Health Care Costs	0	887	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,900	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	335,120	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	4,685	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	4,685	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	15,323	29.00
30.00	Administrative Costs	-19,743	101,468	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-19,743	116,791	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-19,743	456,596	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1318

Period:

Worksheet M-2

Component CCN: 14-3461

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 1:11 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.08	5,274	4,200	8,736		1.00
2.00	Physician Assistant	2.47	7,263	2,100	5,187		2.00
3.00	Nurse Practitioner	2.56	6,170	2,100	5,376		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.11	18,707		19,299	19,299	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	1.50	1,349			1,349	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)	8.61	20,056			20,648	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,995,966	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					71,457	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,067,423	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.976705	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					909,478	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,271,901	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,181,379	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,181,379	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,060,679	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,056,645	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1318

Period:

Worksheet M-2

Component CCN: 14-8621

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 1:11 pm

		RHC II		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	0.55	1,639	4,200	2,310	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.23	747	2,100	483	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.78	2,386		2,793	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.78	2,386		2,793	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)				335,120	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				4,685	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				339,805	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.986213	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				116,791	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				468,945	15.00
16.00	Total overhead (sum of lines 14 and 15)				585,736	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				585,736	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				577,660	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				912,780	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/25/2022 1:11 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)			8,056,645	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			358,150	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			7,698,495	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,648	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)			20,648	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			372.84	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	302.55	8.00
9.00	Rate for Program covered visits (see instructions)	372.84	372.84	302.55	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	1,030	1,277	2,829	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	384,025	476,117	855,914	11.00
12.00	Program covered visits for mental health services (from contractor records)	21	18	50	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	7,830	6,711	15,128	13.00
14.00	Limit adjustment for mental health services (see instructions)	7,830	6,711	15,128	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,745,725		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,261,861		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		20,334		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		28,131		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.)		1,273,854		16.04
16.05	Total program cost (see instructions)	0	1,301,985		16.05
17.00	Primary payer amounts		175		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		125,277		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		223,250		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,301,810		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		119,843		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,421,653		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)		1,421,653		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,131,257		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)		290,396		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1318 Component CCN: 14-8621	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/25/2022 1:11 pm	
		Title XVIII	RHC II	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)			912,780	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			14,215	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			898,565	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,793	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)			2,793	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			321.72	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	209.55	8.00
9.00	Rate for Program covered visits (see instructions)	321.72	321.72	209.55	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	187	739	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	60,162	154,857	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	215,019		16.00
16.01	Total program charges (see instructions)(from contractor's records)		223,891		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,996		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,917		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.)		163,778		16.04
16.05	Total program cost (see instructions)	0	165,695		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,379		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		42,703		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		165,695		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,710		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		171,405		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)		171,405		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		144,924		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)		26,481		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 VACCINE COST

Provider CCN: 14-1318

Period:

Worksheet M-4

Component CCN: 14-3461

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 1:11 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,691,835	2,691,835	2,691,835	2,691,835	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001873	0.006668	0.007216	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5,042	17,949	19,424	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	66,635	24,133	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	71,677	42,082	19,424	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,995,966	2,995,966	2,995,966	2,995,966	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,060,679	5,060,679	5,060,679	5,060,679	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.023925	0.014046	0.006483	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	121,077	71,082	32,808	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	192,754	113,164	52,232	0	10.00
11.00	Total number of injections/infusions (from your records)	438	1,559	1,687	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	440.08	72.59	30.96	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	133	413	699	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			313	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	58,531	29,980	31,332	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		358,150			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		119,843			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1318

Period:

Worksheet M-4

Component CCN: 14-8621

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 1:11 pm

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	316,220	316,220	316,220	316,220	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001607	0.000655	0.000714	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	508	207	226	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,108	170	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,616	377	226	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	335,120	335,120	335,120	335,120	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	577,660	577,660	577,660	577,660	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.013774	0.001125	0.000674	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7,957	650	389	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	12,573	1,027	615	0	10.00
11.00	Total number of injections/infusions (from your records)	27	11	12	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	465.67	93.36	51.25	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	11	3	5	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			1	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,122	280	308	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		14,215			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		5,710			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/25/2022 1:11 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		1,146,044	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		05/21/2021	9,219		3.50
3.51		08/17/2021	5,568		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)		-14,787		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,131,257		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		290,396		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,421,653		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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1318 Component CCN:14-8621	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/25/2022 1:11 pm	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			146,971	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			08/17/2021	2,047	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)			-2,047	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			144,924	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			26,481	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			171,405	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00