

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 4:38 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/25/2019	Time: 4:38 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RED BUD REGIONAL HOSPITAL (14-1348) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) VERONICA MARIN

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	195,029	-1,366,234	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	383,823	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		312,156		0	10.00
200.00	Total	0	578,852	-1,054,078	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: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 4:38 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: ST. CLEMENT BLVD			PO Box:				1.00		
2.00	City: RED BUD			State: IL		Zip Code: 62278-		County: RANDOLPH		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	N	O	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		RED BUD HOSPITAL	14Z348	99914		08/10/2005	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019		20.00
21.00	Type of Control (see instructions)						4			21.00
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 4:38 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
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr	
							1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0	35.00
							Beginning:	Ending:	
							1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							0	37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
							Y/N	Y/N	
							1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)							N	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	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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.							N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.							N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.							N	56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							N	58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							N	59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
						1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)							N	60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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	
					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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
			V 1.00	XIX 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.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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.	Y	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.	Y	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.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
			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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 4:38 pm	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	15,177	72,588	0	
		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
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				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	HB0776		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 4:38 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: QUORUM HEALTH	Contractor's Name: WPS		Contractor's Number: 52280				141.00	
142.00	Street: 1573 MALLORY LANE SUITE 100	PO Box:						142.00	
143.00	City: BRENTWOOD	State: TN		Zip Code: 37027				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	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.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					07/01/2018	06/30/2019		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 4:38 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.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	10/10/2019	Y	10/10/2019
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)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/25/2019 4:38 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.		Y	12/31/2018	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.	JOSEPH	MORAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3613	JOSEPH_MORAN@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/25/2019 4:38 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.	MANAGER, REIMBURSEMENT	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: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	48,288.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	48,288.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	48,288.00	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
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 4:38 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)	1,359	12	2,012			1.00
2.00	HMO and other (see instructions)	247	122				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	2,465	0	3,263			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	251			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,824	12	5,526			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)	3,824	12	5,526	0.00	133.32	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	6,276	0	10,908	0.00	24.04	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	157.36	27.00
28.00	Observation Bed Days		0	631			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: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 4:38 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	429	4	658	1.00
2.00 HMO and other (see instructions)			66	41		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	429	4	658	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
11/25/2019 4:38 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	611,817	17.00
18.00	Medicare Taxes - Employers Portion Only	143,086	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	39,062	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	793,965	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	-7,404	25.00

Health Financial Systems		RED BUD REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1348 Component CCN: 14-8514		Period: From 07/01/2018 To 06/30/2019 Worksheet S-8 Date/Time Prepared: 11/25/2019 4:38 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	325 SPRING STREET			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	RED BUD		IL	62278
				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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
	Facility hours of operations (1)				
11.00	CLINIC	08:00		05:00	08:00
				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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	RANDOLPH			
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
	Facility hours of operations (1)				
11.00	CLINIC	05:00	08:00	05:00	08:00
				05:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1348

Period:

Worksheet S-8

Component CCN: 14-8514

From 07/01/2018
To 06/30/2019

Date/Time Prepared:

11/25/2019 4:38 pm

		RHC I		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1)				
	CLINIC	08:00	05:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-10

Date/Time Prepared:
11/25/2019 4:38 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)		0.154450	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		7,731,408	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,410,613	5.00
6.00	Medicaid charges		100,144,391	6.00
7.00	Medicaid cost (line 1 times line 6)		15,467,301	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)		5,325,280	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)		5,325,280	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)	12,566,171	0	12,566,171
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,940,845	0	1,940,845
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,940,845	0	1,940,845
			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)		17,424,400	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		357,170	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		549,492	27.01
28.00	Non-Medicare bad debt expense (see instructions)		16,874,908	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,798,652	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,739,497	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,064,777	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet A Date/Time Prepared: 11/25/2019 4:38 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		392,050	392,050	81,370	473,420	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		906,336	906,336	235,624	1,141,960	2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	145,665	108,855	254,520	1,413,473	1,667,993	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,306,228	5,640,873	6,947,101	-1,594,487	5,352,614	5.00	
7.00	00700	OPERATION OF PLANT	209,112	944,195	1,153,307	-40,032	1,113,275	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,822	83,822	0	83,822	8.00	
9.00	00900	HOUSEKEEPING	179,690	44,935	224,625	-115	224,510	9.00	
10.00	01000	DIETARY	0	841,916	841,916	-138,914	703,002	10.00	
11.00	01100	CAFETERIA	0	0	0	138,494	138,494	11.00	
13.00	01300	NURSING ADMINISTRATION	587,247	262,434	849,681	-222,153	627,528	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	31,939	322,670	354,609	-274,383	80,226	14.00	
15.00	01500	PHARMACY	330,371	680,319	1,010,690	-611,379	399,311	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	272,265	111,942	384,207	-8,522	375,685	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	1,715,106	326,410	2,041,516	182,648	2,224,164	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	278,272	142,791	421,063	-9,076	411,987	50.00	
53.00	05300	ANESTHESIOLOGY	0	81,965	81,965	259,088	341,053	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	600,686	779,649	1,380,335	-98,574	1,281,761	54.00	
60.00	06000	LABORATORY	482,668	495,466	978,134	-46,281	931,853	60.00	
65.00	06500	RESPIRATORY THERAPY	161,073	51,839	212,912	-23,640	189,272	65.00	
66.00	06600	PHYSICAL THERAPY	523,522	59,877	583,399	-1,117	582,282	66.00	
67.00	06700	OCCUPATIONAL THERAPY	139,459	11,963	151,422	0	151,422	67.00	
68.00	06800	SPEECH PATHOLOGY	51,967	8,666	60,633	0	60,633	68.00	
69.00	06900	ELECTROCARDIOLOGY	18,284	1,322	19,606	6,336	25,942	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	111,245	111,245	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168,386	168,386	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	655,984	655,984	73.00	
76.00	03610	BLANK	0	0	0	0	0	76.00	
76.01	03550	SLEEP LAB	5,699	6,844	12,543	0	12,543	76.01	
76.02	03020	PSYCH SERVICES	211	263,093	263,304	-617	262,687	76.02	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	2,222,754	480,976	2,703,730	-82,734	2,620,996	88.00	
91.00	09100	EMERGENCY	2,144,390	811,766	2,956,156	-403,337	2,552,819	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)	11,406,608	13,862,974	25,269,582	-302,713	24,966,869	118.00	
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-38,785	-38,785	57,854	19,069	192.00	
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00	
194.01	07951	MARKETING	0	0	0	113,583	113,583	194.01	
194.02	07952	SENIOR CIRCLE	37,528	10,658	48,186	-3,194	44,992	194.02	
194.03	07953	RED BUD SPECIALTY CLINIC	133,443	14,701	148,144	-60,919	87,225	194.03	
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04	
194.05	07955	FREE STANDING NURSING HOME	0	0	0	195,389	195,389	194.05	
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06	
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07	
200.00		TOTAL (SUM OF LINES 118 through 199)	11,577,579	13,849,548	25,427,127	0	25,427,127	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet A
Date/Time Prepared:
11/25/2019 4:38 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	98,083	571,503	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-188,502	953,458	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-201	1,667,792	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,512,767	3,839,847	5.00
7.00	00700	OPERATION OF PLANT	-26,396	1,086,879	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,822	8.00
9.00	00900	HOUSEKEEPING	0	224,510	9.00
10.00	01000	DIETARY	468,967	1,171,969	10.00
11.00	01100	CAFETERIA	-3,012	135,482	11.00
13.00	01300	NURSING ADMINISTRATION	0	627,528	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,226	14.00
15.00	01500	PHARMACY	0	399,311	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-618	375,067	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-193,243	2,030,921	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	411,987	50.00
53.00	05300	ANESTHESIOLOGY	-334,426	6,627	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-39,095	1,242,666	54.00
60.00	06000	LABORATORY	-60,054	871,799	60.00
65.00	06500	RESPIRATORY THERAPY	0	189,272	65.00
66.00	06600	PHYSICAL THERAPY	0	582,282	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	151,422	67.00
68.00	06800	SPEECH PATHOLOGY	0	60,633	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,942	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	111,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	168,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-565	655,419	73.00
76.00	03610	BLANK	0	0	76.00
76.01	03550	SLEEP LAB	0	12,543	76.01
76.02	03020	PSYCH SERVICES	0	262,687	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-515,352	2,105,644	88.00
91.00	09100	EMERGENCY	-733,912	1,818,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,041,093	21,925,776	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19,069	192.00
194.00	07950	HOME HEALTH	0	0	194.00
194.01	07951	MARKETING	0	113,583	194.01
194.02	07952	SENIOR CIRCLE	0	44,992	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	87,225	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	195,389	194.05
194.06	07956	CLINIC CORPORATION	0	0	194.06
194.07	07957	VACANT SPACE	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,041,093	22,386,034	200.00

RECLASSIFICATIONS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
11/25/2019 4:38 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,514,286		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	63,325		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	1,577,611		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,938		1.00
	0		0	10,938		
	C - RENTAL EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	228,932		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	57,854		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	286,786		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,697		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,692		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	47,673		3.00
	0		0	88,062		
	E - MARKETING COSTS					
1.00	MARKETING	194.01	61,347	52,236		1.00
	0		61,347	52,236		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	100,307		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	168,386		2.00
	0		0	268,693		
	G - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	601,401		1.00
	0		0	601,401		
	H - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	0	138,494		1.00
	0		0	138,494		
	I - ALLOCATE NUSRSING HOME COSTS					
1.00	FREE STANDING NURSING HOME	194.05	186,533	8,856		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		186,533	8,856		
	K - RECLASS ANESTHESIA COSTS					
1.00	ANESTHESIOLOGY	53.00	0	259,134		1.00
	0		0	259,134		
	L - RECLASS MALPRACTICE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	103,951		1.00
	0		0	103,951		
	M - RECLASS SALARIES IN SPECIALTY CLINIC					
1.00	DRUGS CHARGED TO PATIENTS	73.00	54,583	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	6,336	0		2.00
	TOTALS		60,919	0		
	N - RECLASS HOUSE SUPERVISOR FROM ADMIN					
1.00	EMERGENCY	91.00	4,167	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	194,300	0		2.00
	TOTALS		198,467	0		
500.00	Grand Total: Increases		507,266	3,396,162		500.00

RECLASSIFICATIONS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
11/25/2019 4:38 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	55,838	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,371,664	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3,400	0		3.00
4.00	EMERGENCY	91.00	0	146,709	0		4.00
			0	1,577,611			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	10,938	0		1.00
			0	10,938			
	C - RENTAL EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,688	10		1.00
2.00	OPERATION OF PLANT	7.00	0	600	0		2.00
3.00	HOUSEKEEPING	9.00	0	115	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	1,099	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,690	0		5.00
6.00	PHARMACY	15.00	0	9,978	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,568	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	8,252	0		8.00
9.00	OPERATING ROOM	50.00	0	9,076	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	46	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	98,574	0		11.00
12.00	LABORATORY	60.00	0	46,281	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	12,702	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,117	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	42,108	0		15.00
16.00	EMERGENCY	91.00	0	1,661	0		16.00
17.00	SENIOR CIRCLE	194.02	0	3,194	0		17.00
18.00	PSYCH SERVICES	76.02	0	617	0		18.00
19.00	DIETARY	10.00	0	420	0		19.00
			0	286,786			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	88,062	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
			0	88,062			
	E - MARKETING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	61,347	52,236	0		1.00
			61,347	52,236			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	268,693	0		1.00
2.00		0.00	0	0	0		2.00
			0	268,693			
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	601,401	0		1.00
			0	601,401			
	H - CAFETERIA COSTS						
1.00	DIETARY	10.00	0	138,494	0		1.00
			0	138,494			
	I - ALLOCATE NURSING HOME COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	41,846	3,129	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	79,886	2,555	0		2.00
3.00	OPERATION OF PLANT	7.00	36,564	2,868	0		3.00
4.00	NURSING ADMINISTRATION	13.00	22,283	304	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	5,954	0	0		5.00
			186,533	8,856			
	K - RECLASS ANESTHESIA COSTS						
1.00	EMERGENCY	91.00	0	259,134	0		1.00
			0	259,134			
	L - RECLASS MALPRACTICE EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	103,951	0		1.00
			0	103,951			
	M - RECLASS SALARIES IN SPECIALTY CLINIC						
1.00	RED BUD SPECIALTY CLINIC	194.03	60,919	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		60,919	0			
	N - RECLASS HOUSE SUPERVISOR FROM ADMIN						
1.00	NURSING ADMINISTRATION	13.00	198,467	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		198,467	0			
500.00	Grand Total: Decreases		507,266	3,396,162			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	311,428	0	0	0	0	2.00	
3.00	Buildings and Fixtures	5,093,698	904	0	904	0	3.00	
4.00	Building Improvements	7,950,067	29,826	0	29,826	93,716	4.00	
5.00	Fixed Equipment	2,609,867	0	0	0	30,690	5.00	
6.00	Movable Equipment	9,170,782	591,164	0	591,164	553,841	6.00	
7.00	HIT designated Assets	3,075,707	0	0	0	15,039	7.00	
8.00	Subtotal (sum of lines 1-7)	28,211,549	621,894	0	621,894	693,286	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	28,211,549	621,894	0	621,894	693,286	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	311,428	0				2.00	
3.00	Buildings and Fixtures	5,094,602	0				3.00	
4.00	Building Improvements	7,886,177	0				4.00	
5.00	Fixed Equipment	2,579,177	0				5.00	
6.00	Movable Equipment	9,208,105	0				6.00	
7.00	HIT designated Assets	3,060,668	0				7.00	
8.00	Subtotal (sum of lines 1-7)	28,140,157	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	28,140,157	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/25/2019 4:38 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	392,050	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	906,336	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,298,386	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	392,050				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	906,336				2.00
3.00	Total (sum of lines 1-2)	0	1,298,386				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/25/2019 4:38 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	13,292,207	0	13,292,207	0.472357	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,847,950	0	14,847,950	0.527643	0	2.00
3.00	Total (sum of lines 1-2)	28,140,157	0	28,140,157	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	490,133	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	717,834	228,932	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,207,967	228,932	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	81,370	0	0	571,503	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,692	0	953,458	2.00
3.00	Total (sum of lines 1-2)	0	81,370	6,692	0	1,524,961	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-13,915	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-886	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-941,353			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-94	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	7,167			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-3,012	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-565	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-618	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	59,949	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-195,362	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
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PATIENT TELEPHONE BENEFITS EXPENSE	A	-201	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
36.00	OTHER MISC REVENUE	B	-90,098	ADMINISTRATIVE & GENERAL	5.00	0	36.00
38.00	NON RHC COSTS	A	-479,821	RURAL HEALTH CLINIC	88.00	0	38.00
38.03	TELEPHONE SERVICES	A	-2,959	ADMINISTRATIVE & GENERAL	5.00	0	38.03
38.04	TELEPHONE DEPRECIATION	A	-2,116	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.04
39.00	ADVERTISING	A	-84,490	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01	PROFESSIONAL FEE BENEFITS	A	-22,352	ADULTS & PEDIATRICS	30.00	0	39.01
39.02	RADIOLOGY NURSING HOME COST	A	-3,001	RADIOLOGY-DIAGNOSTIC	54.00	0	39.02
39.03	LAB NURSING HOME COST	A	-9,795	LABORATORY	60.00	0	39.03
41.00	PROFESSIONAL FEE BENEFITS	A	-49,709	EMERGENCY	91.00	0	41.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-5,790	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	LOBBYING EXPENSE	A	-8,250	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.01	CRNA COSTS	A	-314,866	ANESTHESIOLOGY	53.00	0	45.01
45.02	CRNA BENEFITS	A	-19,560	ANESTHESIOLOGY	53.00	0	45.02
45.03	ILLINOIS PROVIDER TAX	A	-1,259,263	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	ADD BACK NH CREDIT FOR DIETARY	A	468,967	DIETARY	10.00	0	45.04
45.06	MISCELLANEOUS RHC INCOME	B	-35,531	RURAL HEALTH CLINIC	88.00	0	45.06
45.07	CHARITABLE CONTRIBUTIONS	A	-2,754	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	NON ALLOWABLE EXPENSE	A	-4,419	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	PATIENT TV - CABLE EXPENSE	A	-26,396	OPERATION OF PLANT	7.00	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,041,093				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: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
11/25/2019 4:38 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	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	185,516	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	38,134	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	9,862	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	482,440	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	87,765	264,391	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	532,159	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			803,717	796,550	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	QUORUM HEALTH C	100.00	QUORUM HEALTH C	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
11/25/2019 4:38 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	0	0		1.00
2.00	185,516	0		2.00
3.00	38,134	9		3.00
4.00	9,862	9		4.00
4.01	482,440	0		4.01
4.02	-176,626	0		4.02
4.03	-532,159	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	7,167			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	HOSPITAL CORP		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: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-2

Date/Time Prepared:
11/25/2019 4:38 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	170,891	170,891	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	36,000	36,000	0	0	0	6.00
7.00	60.00	LABORATORY	50,259	50,259	0	0	0	7.00
8.00	91.00	EMERGENCY	1,425,423	684,203	741,220	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			1,682,573	941,353	741,220		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	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	170,891		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	50.00	OPERATING ROOM	0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	36,000		6.00
7.00	60.00	LABORATORY	0	0	0	50,259		7.00
8.00	91.00	EMERGENCY	0	0	0	684,203		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	941,353		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 4:38 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	571,503	571,503			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	953,458		953,458		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,667,792	10,544	18,280	1,696,616	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,839,847	85,305	147,889	172,267	5.00
7.00	00700	OPERATION OF PLANT	1,086,879	130,453	226,159	25,515	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,822	1,260	2,185	0	8.00
9.00	00900	HOUSEKEEPING	224,510	9,101	15,779	26,571	9.00
10.00	01000	DIETARY	1,171,969	24,322	42,166	0	10.00
11.00	01100	CAFETERIA	135,482	14,330	24,843	0	11.00
13.00	01300	NURSING ADMINISTRATION	627,528	6,631	11,495	54,194	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,226	5,179	8,978	4,723	14.00
15.00	01500	PHARMACY	399,311	6,877	11,923	48,852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375,067	14,499	25,136	39,379	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,030,921	58,672	101,717	282,342	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	411,987	32,579	56,480	41,148	50.00
53.00	05300	ANESTHESIOLOGY	6,627	699	1,211	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,242,666	22,655	39,276	88,823	54.00
60.00	06000	LABORATORY	871,799	13,161	22,817	71,372	60.00
65.00	06500	RESPIRATORY THERAPY	189,272	1,644	2,850	23,818	65.00
66.00	06600	PHYSICAL THERAPY	582,282	18,440	31,969	77,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,422	2,265	3,927	20,622	67.00
68.00	06800	SPEECH PATHOLOGY	60,633	0	0	7,684	68.00
69.00	06900	ELECTROCARDIOLOGY	25,942	1,142	1,979	3,641	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	111,245	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	168,386	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	655,419	0	0	8,071	73.00
76.00	03610	BLANK	0	0	0	0	76.00
76.01	03550	SLEEP LAB	12,543	4,507	7,814	843	76.01
76.02	03020	PSYCH SERVICES	262,687	9,978	17,299	31	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,105,644	40,196	69,685	328,676	88.00
91.00	09100	EMERGENCY	1,818,907	13,791	23,909	317,705	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,925,776	528,230	915,766	1,643,690	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	19,069	17,024	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING	113,583	1,480	2,565	9,071	194.01
194.02	07952	SENIOR CIRCLE	44,992	2,959	5,130	5,549	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	87,225	17,303	29,997	10,724	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	195,389	0	0	27,582	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	4,507	0	0	194.07
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	22,386,034	571,503	953,458	1,696,616	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,245,308					5.00
7.00	00700	OPERATION OF PLANT	348,758	1,817,764				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,718	6,981	114,966			8.00
9.00	00900	HOUSEKEEPING	65,516	50,412	14,782	406,671		9.00
10.00	01000	DIETARY	294,023	134,719	2,173	29,540	1,698,912	10.00
11.00	01100	CAFETERIA	41,465	79,374	0	17,404	0	11.00
13.00	01300	NURSING ADMINISTRATION	166,152	36,728	0	8,053	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,529	28,684	0	6,289	0	14.00
15.00	01500	PHARMACY	110,862	38,094	0	8,353	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,804	80,310	0	17,609	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	587,272	324,983	44,481	71,259	269,811	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	128,723	180,451	7,957	39,567	0	50.00
53.00	05300	ANESTHESIOLOGY	2,027	3,870	0	849	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	330,813	125,486	14,205	27,515	0	54.00
60.00	06000	LABORATORY	232,461	72,899	98	15,984	0	60.00
65.00	06500	RESPIRATORY THERAPY	51,657	9,106	0	1,997	0	65.00
66.00	06600	PHYSICAL THERAPY	168,587	102,139	6,123	22,396	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,315	12,546	0	2,751	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,219	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,764	6,324	0	1,387	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,411	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,977	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,520	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	6,103	24,966	0	5,474	0	76.01
76.02	03020	PSYCH SERVICES	68,848	55,268	0	12,119	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	604,025	222,642	159	48,818	0	88.00
91.00	09100	EMERGENCY	516,206	76,389	23,551	16,750	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)	4,165,755	1,672,371	113,529	354,114	269,811	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	20,677	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	30,080	8,195	0	1,797	0	194.01
194.02	07952	SENIOR CIRCLE	13,919	16,391	0	3,594	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	34,484	95,841	1,437	21,015	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	1,429,101	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	1,070	24,966	0	5,474	0	194.07
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)	4,245,308	1,817,764	114,966	406,671	1,698,912	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	312,898					11.00
13.00	01300	NURSING ADMINISTRATION	16,467	927,248				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,499	0	160,107			14.00
15.00	01500	PHARMACY	6,422	63,454	1,971	696,119		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,594	0	788	0	673,186	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	77,063	366,738	21,775	0	75,595	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,121	53,447	12,268	0	46,514	50.00
53.00	05300	ANESTHESIOLOGY	0	0	619	0	1,325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,289	0	10,089	0	187,359	54.00
60.00	06000	LABORATORY	21,864	0	33,600	0	146,900	60.00
65.00	06500	RESPIRATORY THERAPY	6,022	30,937	1,590	0	10,229	65.00
66.00	06600	PHYSICAL THERAPY	18,266	0	539	0	40,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,948	0	103	0	12,974	67.00
68.00	06800	SPEECH PATHOLOGY	1,499	0	16	0	2,373	68.00
69.00	06900	ELECTROCARDIOLOGY	1,074	0	0	0	14,521	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	22,555	0	13,773	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	28,739	0	4,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,924	0	0	696,119	28,996	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	275	0	49	0	802	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	666	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	60,071	0	13,467	0	18,005	88.00
91.00	09100	EMERGENCY	40,630	412,672	11,361	0	68,755	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)	303,028	927,248	159,529	696,119	673,186	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	378	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,499	0	120	0	0	194.01
194.02	07952	SENIOR CIRCLE	1,999	0	80	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	5,372	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	312,898	927,248	160,107	696,119	673,186	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,312,629	0	4,312,629	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,019,242	0	1,019,242	50.00
53.00	05300	ANESTHESIOLOGY	17,227	0	17,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,112,176	0	2,112,176	54.00
60.00	06000	LABORATORY	1,502,955	0	1,502,955	60.00
65.00	06500	RESPIRATORY THERAPY	329,122	0	329,122	65.00
66.00	06600	PHYSICAL THERAPY	1,068,273	0	1,068,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,873	0	253,873	67.00
68.00	06800	SPEECH PATHOLOGY	88,424	0	88,424	68.00
69.00	06900	ELECTROCARDIOLOGY	63,774	0	63,774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	173,984	0	173,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,382	0	241,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,548,049	0	1,548,049	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	63,376	0	63,376	76.01
76.02	03020	PSYCH SERVICES	426,896	0	426,896	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,511,388	0	3,511,388	88.00
91.00	09100	EMERGENCY	3,340,626	0	3,340,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,073,396	0	20,073,396	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,148	0	57,148	192.00
194.00	07950	HOME HEALTH	0	0	0	194.00
194.01	07951	MARKETING	169,390	0	169,390	194.01
194.02	07952	SENIOR CIRCLE	94,613	0	94,613	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	303,398	0	303,398	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	1,652,072	0	1,652,072	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	194.06
194.07	07957	VACANT SPACE	36,017	0	36,017	194.07
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,386,034	0	22,386,034	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,544	18,280	28,824	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	85,305	147,889	233,194	5.00
7.00	00700	OPERATION OF PLANT	0	130,453	226,159	356,612	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,260	2,185	3,445	8.00
9.00	00900	HOUSEKEEPING	0	9,101	15,779	24,880	9.00
10.00	01000	DIETARY	0	24,322	42,166	66,488	10.00
11.00	01100	CAFETERIA	0	14,330	24,843	39,173	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,631	11,495	18,126	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,179	8,978	14,157	14.00
15.00	01500	PHARMACY	0	6,877	11,923	18,800	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,499	25,136	39,635	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	58,672	101,717	160,389	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	32,579	56,480	89,059	50.00
53.00	05300	ANESTHESIOLOGY	0	699	1,211	1,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,655	39,276	61,931	54.00
60.00	06000	LABORATORY	0	13,161	22,817	35,978	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,644	2,850	4,494	65.00
66.00	06600	PHYSICAL THERAPY	0	18,440	31,969	50,409	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,265	3,927	6,192	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,142	1,979	3,121	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	03610	BLANK	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	4,507	7,814	12,321	76.01
76.02	03020	PSYCH SERVICES	0	9,978	17,299	27,277	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	40,196	69,685	109,881	88.00
91.00	09100	EMERGENCY	0	13,791	23,909	37,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	528,230	915,766	1,443,996	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,024	0	17,024	192.00
194.00	07950	HOME HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,480	2,565	4,045	194.01
194.02	07952	SENIOR CIRCLE	0	2,959	5,130	8,089	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	17,303	29,997	47,300	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	4,507	0	4,507	194.07
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	571,503	953,458	1,524,961	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	236,120					5.00
7.00	00700	OPERATION OF PLANT	19,398	376,443				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,152	1,446	6,043			8.00
9.00	00900	HOUSEKEEPING	3,644	10,440	777	40,192		9.00
10.00	01000	DIETARY	16,354	27,899	114	2,919	113,774	10.00
11.00	01100	CAFETERIA	2,306	16,438	0	1,720	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,241	7,606	0	796	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,309	5,940	0	622	0	14.00
15.00	01500	PHARMACY	6,166	7,889	0	826	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,996	16,632	0	1,740	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,665	67,300	2,338	7,042	18,069	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,160	37,370	418	3,911	0	50.00
53.00	05300	ANESTHESIOLOGY	113	801	0	84	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,400	25,987	747	2,719	0	54.00
60.00	06000	LABORATORY	12,930	15,097	5	1,580	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,873	1,886	0	197	0	65.00
66.00	06600	PHYSICAL THERAPY	9,377	21,152	322	2,213	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,354	2,598	0	272	0	67.00
68.00	06800	SPEECH PATHOLOGY	902	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	432	1,310	0	137	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,469	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,224	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,761	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	339	5,170	0	541	0	76.01
76.02	03020	PSYCH SERVICES	3,829	11,446	0	1,198	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	33,589	46,107	8	4,825	0	88.00
91.00	09100	EMERGENCY	28,712	15,820	1,238	1,655	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)	231,695	346,334	5,967	34,997	18,069	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	2,044	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,673	1,697	0	178	0	194.01
194.02	07952	SENIOR CIRCLE	774	3,394	0	355	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	1,918	19,848	76	2,077	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	95,705	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	60	5,170	0	541	0	194.07
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)	236,120	376,443	6,043	40,192	113,774	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	59,637					11.00
13.00	01300	NURSING ADMINISTRATION	3,139	39,829				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	476	0	22,584			14.00
15.00	01500	PHARMACY	1,224	2,726	278	38,739		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,400	0	111	0	67,183	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,688	15,753	3,072	0	7,545	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,548	2,296	1,730	0	4,642	50.00
53.00	05300	ANESTHESIOLOGY	0	0	87	0	132	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,439	0	1,423	0	18,695	54.00
60.00	06000	LABORATORY	4,167	0	4,741	0	14,662	60.00
65.00	06500	RESPIRATORY THERAPY	1,148	1,329	224	0	1,021	65.00
66.00	06600	PHYSICAL THERAPY	3,481	0	76	0	4,004	66.00
67.00	06700	OCCUPATIONAL THERAPY	943	0	14	0	1,295	67.00
68.00	06800	SPEECH PATHOLOGY	286	0	2	0	237	68.00
69.00	06900	ELECTROCARDIOLOGY	205	0	0	0	1,449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,181	0	1,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,054	0	427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367	0	0	38,739	2,894	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	52	0	7	0	80	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	66	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,449	0	1,900	0	1,797	88.00
91.00	09100	EMERGENCY	7,744	17,725	1,603	0	6,862	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)	57,756	39,829	22,503	38,739	67,183	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	53	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	476	0	17	0	0	194.01
194.02	07952	SENIOR CIRCLE	381	0	11	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	1,024	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	59,637	39,829	22,584	38,739	67,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	333,657	0	333,657	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	148,833	0	148,833	50.00
53.00	05300	ANESTHESIOLOGY	3,127	0	3,127	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,850	0	135,850	54.00
60.00	06000	LABORATORY	90,372	0	90,372	60.00
65.00	06500	RESPIRATORY THERAPY	13,577	0	13,577	65.00
66.00	06600	PHYSICAL THERAPY	92,349	0	92,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,018	0	14,018	67.00
68.00	06800	SPEECH PATHOLOGY	1,558	0	1,558	68.00
69.00	06900	ELECTROCARDIOLOGY	6,716	0	6,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,025	0	6,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,705	0	6,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,898	0	50,898	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	18,524	0	18,524	76.01
76.02	03020	PSYCH SERVICES	43,817	0	43,817	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	215,143	0	215,143	88.00
91.00	09100	EMERGENCY	124,456	0	124,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,305,625	0	1,305,625	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,121	0	19,121	192.00
194.00	07950	HOME HEALTH	0	0	0	194.00
194.01	07951	MARKETING	8,240	0	8,240	194.01
194.02	07952	SENIOR CIRCLE	13,098	0	13,098	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	72,425	0	72,425	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	96,174	0	96,174	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	194.06
194.07	07957	VACANT SPACE	10,278	0	10,278	194.07
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,524,961	0	1,524,961	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	125,147					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		120,432				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,309	2,309	11,473,760			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,680	18,680	1,164,995	-4,245,308	17,881,662	5.00
7.00	00700	OPERATION OF PLANT	28,566	28,566	172,548	0	1,469,006	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	276	0	0	87,267	8.00
9.00	00900	HOUSEKEEPING	1,993	1,993	179,690	0	275,961	9.00
10.00	01000	DIETARY	5,326	5,326	0	0	1,238,457	10.00
11.00	01100	CAFETERIA	3,138	3,138	0	0	174,655	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	1,452	366,497	0	699,848	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	1,134	31,939	0	99,106	14.00
15.00	01500	PHARMACY	1,506	1,506	330,371	0	466,963	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	3,175	266,311	0	454,081	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,848	12,848	1,909,406	0	2,473,652	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,134	7,134	278,272	0	542,194	50.00
53.00	05300	ANESTHESIOLOGY	153	153	0	0	8,537	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	4,961	600,686	0	1,393,420	54.00
60.00	06000	LABORATORY	2,882	2,882	482,668	0	979,149	60.00
65.00	06500	RESPIRATORY THERAPY	360	360	161,073	0	217,584	65.00
66.00	06600	PHYSICAL THERAPY	4,038	4,038	523,522	0	710,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	496	139,459	0	178,236	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	51,967	0	68,317	68.00
69.00	06900	ELECTROCARDIOLOGY	250	250	24,620	0	32,704	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	111,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	168,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	54,583	0	663,490	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	987	987	5,699	0	25,707	76.01
76.02	03020	PSYCH SERVICES	2,185	2,185	211	0	289,995	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,802	8,802	2,222,754	0	2,544,201	88.00
91.00	09100	EMERGENCY	3,020	3,020	2,148,557	0	2,174,312	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)	115,671	115,671	11,115,828	-4,245,308	17,546,577	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,728	0	0	-36,093	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	324	324	61,347	0	126,699	194.01
194.02	07952	SENIOR CIRCLE	648	648	37,528	0	58,630	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	3,789	72,524	0	145,249	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	186,533	-222,971	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	987	0	0	0	4,507	194.07
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)	571,503	953,458	1,696,616		4,245,308	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.566654	7.916982	0.147869		0.237411	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			28,824		236,120	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002512		0.013205	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: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description		OPERATION OF PLANT (NUMBER HOUSED)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	71,864				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	172,130			8.00
9.00	00900	HOUSEKEEPING	1,993	22,132	73,323		9.00
10.00	01000	DIETARY	5,326	3,253	5,326	117,370	10.00
11.00	01100	CAFETERIA	3,138	0	3,138	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	0	1,452	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	0	1,134	0	14.00
15.00	01500	PHARMACY	1,506	0	1,506	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	0	3,175	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,848	66,599	12,848	18,640	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,134	11,913	7,134	0	50.00
53.00	05300	ANESTHESIOLOGY	153	0	153	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	21,268	4,961	0	54.00
60.00	06000	LABORATORY	2,882	147	2,882	0	60.00
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	65.00
66.00	06600	PHYSICAL THERAPY	4,038	9,168	4,038	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	0	496	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	250	0	250	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	03610	BLANK	0	0	0	0	76.00
76.01	03550	SLEEP LAB	987	0	987	0	76.01
76.02	03020	PSYCH SERVICES	2,185	0	2,185	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,802	238	8,802	0	88.00
91.00	09100	EMERGENCY	3,020	35,261	3,020	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)	66,116	169,979	63,847	18,640	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,728	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING	324	0	324	0	194.01
194.02	07952	SENIOR CIRCLE	648	0	648	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	2,151	3,789	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	98,730	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07	07957	VACANT SPACE	987	0	987	0	194.07
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)	1,817,764	114,966	406,671	1,698,912	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.294501	0.667902	5.546295	14.474840	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	376,443	6,043	40,192	113,774	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.238270	0.035107	0.548150	0.969362	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: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	4,827,679			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	839,658		14.00
15.00	01500	PHARMACY	330,371	10,338	601,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,130	0	16.00
					129,967,016	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,909,406	114,196	0	30.00
					14,593,570	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	278,272	64,338	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,246	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,910	0	54.00
60.00	06000	LABORATORY	0	176,211	0	60.00
65.00	06500	RESPIRATORY THERAPY	161,073	8,338	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,827	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	539	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	84	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	118,284	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	150,718	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	601,401	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	0	258	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	76.02
					128,599	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	70,625	0	88.00
91.00	09100	EMERGENCY	2,148,557	59,583	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)	4,827,679	836,625	601,401	118.00
					129,967,016	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,982	0	192.00
194.00	07950	HOME HEALTH	0	0	0	194.00
194.01	07951	MARKETING	0	630	0	194.01
194.02	07952	SENIOR CIRCLE	0	421	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	194.07
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)	927,248	160,107	696,119	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.192069	0.190681	1.157496	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,829	22,584	38,739	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008250	0.026897	0.064415	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: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

				Title XVIII	Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,312,629		4,312,629	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,019,242		1,019,242	0	0	50.00
53.00	05300	ANESTHESIOLOGY	17,227		17,227	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,112,176		2,112,176	0	0	54.00
60.00	06000	LABORATORY	1,502,955		1,502,955	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	329,122	0	329,122	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,068,273	0	1,068,273	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,873	0	253,873	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	88,424	0	88,424	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	63,774		63,774	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	173,984		173,984	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,382		241,382	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,548,049		1,548,049	0	0	73.00
76.00	03610	BLANK	0		0	0	0	76.00
76.01	03550	SLEEP LAB	63,376		63,376	0	0	76.01
76.02	03020	PSYCH SERVICES	426,896		426,896	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,511,388		3,511,388	0	0	88.00
91.00	09100	EMERGENCY	3,340,626		3,340,626	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	456,547		456,547		0	92.00
200.00		Subtotal (see instructions)	20,529,943	0	20,529,943	0	0	200.00
201.00		Less Observation Beds	456,547		456,547		0	201.00
202.00		Total (see instructions)	20,073,396	0	20,073,396	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 4:38 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	12,542,024		12,542,024			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,364,855	7,614,630	8,979,485	0.113508	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	42,467	213,251	255,718	0.067367	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,048,569	33,129,325	36,177,894	0.058383	0.000000	54.00
60.00	06000	LABORATORY	6,383,818	21,975,324	28,359,142	0.052997	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,793,925	180,876	1,974,801	0.166661	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,119,137	3,625,769	7,744,906	0.137932	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,331,109	173,582	2,504,691	0.101359	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	322,548	135,569	458,117	0.193016	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	269,272	2,534,086	2,803,358	0.022749	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,961,675	697,197	2,658,872	0.065435	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	285,784	540,513	826,297	0.292125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,206,126	3,391,632	5,597,758	0.276548	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	154,767	154,767	0.409493	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	128,599	128,599	3.319590	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,475,892	3,475,892			88.00
91.00	09100	EMERGENCY	537,635	12,735,514	13,273,149	0.251683	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	265,433	1,786,113	2,051,546	0.222538	0.000000	92.00
200.00		Subtotal (see instructions)	37,474,377	92,492,639	129,967,016			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	37,474,377	92,492,639	129,967,016			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 4:38 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
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
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	03610 BLANK	0.000000			76.00
76.01	03550 SLEEP LAB	0.000000			76.01
76.02	03020 PSYCH SERVICES	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 4:38 pm

				Title XIX	Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,312,629		4,312,629	0	4,312,629	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,019,242		1,019,242	0	1,019,242	50.00
53.00	05300	ANESTHESIOLOGY	17,227		17,227	0	17,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,112,176		2,112,176	0	2,112,176	54.00
60.00	06000	LABORATORY	1,502,955		1,502,955	0	1,502,955	60.00
65.00	06500	RESPIRATORY THERAPY	329,122	0	329,122	0	329,122	65.00
66.00	06600	PHYSICAL THERAPY	1,068,273	0	1,068,273	0	1,068,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,873	0	253,873	0	253,873	67.00
68.00	06800	SPEECH PATHOLOGY	88,424	0	88,424	0	88,424	68.00
69.00	06900	ELECTROCARDIOLOGY	63,774		63,774	0	63,774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	173,984		173,984	0	173,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,382		241,382	0	241,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,548,049		1,548,049	0	1,548,049	73.00
76.00	03610	BLANK	0		0	0	0	76.00
76.01	03550	SLEEP LAB	63,376		63,376	0	63,376	76.01
76.02	03020	PSYCH SERVICES	426,896		426,896	0	426,896	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,511,388		3,511,388	0	3,511,388	88.00
91.00	09100	EMERGENCY	3,340,626		3,340,626	0	3,340,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	456,547		456,547		456,547	92.00
200.00		Subtotal (see instructions)	20,529,943	0	20,529,943	0	20,529,943	200.00
201.00		Less Observation Beds	456,547		456,547		456,547	201.00
202.00		Total (see instructions)	20,073,396	0	20,073,396	0	20,073,396	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 4:38 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	12,542,024		12,542,024			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,364,855	7,614,630	8,979,485	0.113508	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	42,467	213,251	255,718	0.067367	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,048,569	33,129,325	36,177,894	0.058383	0.000000	54.00
60.00	06000	LABORATORY	6,383,818	21,975,324	28,359,142	0.052997	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,793,925	180,876	1,974,801	0.166661	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,119,137	3,625,769	7,744,906	0.137932	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,331,109	173,582	2,504,691	0.101359	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	322,548	135,569	458,117	0.193016	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	269,272	2,534,086	2,803,358	0.022749	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,961,675	697,197	2,658,872	0.065435	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	285,784	540,513	826,297	0.292125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,206,126	3,391,632	5,597,758	0.276548	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	154,767	154,767	0.409493	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	128,599	128,599	3.319590	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,475,892	3,475,892	1.010212	0.000000	88.00
91.00	09100	EMERGENCY	537,635	12,735,514	13,273,149	0.251683	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	265,433	1,786,113	2,051,546	0.222538	0.000000	92.00
200.00		Subtotal (see instructions)	37,474,377	92,492,639	129,967,016			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	37,474,377	92,492,639	129,967,016			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 4:38 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	0.113508			50.00
53.00	05300 ANESTHESIOLOGY	0.067367			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.058383			54.00
60.00	06000 LABORATORY	0.052997			60.00
65.00	06500 RESPIRATORY THERAPY	0.166661			65.00
66.00	06600 PHYSICAL THERAPY	0.137932			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.101359			67.00
68.00	06800 SPEECH PATHOLOGY	0.193016			68.00
69.00	06900 ELECTROCARDIOLOGY	0.022749			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.065435			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.292125			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276548			73.00
76.00	03610 BLANK	0.000000			76.00
76.01	03550 SLEEP LAB	0.409493			76.01
76.02	03020 PSYCH SERVICES	3.319590			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.010212			88.00
91.00	09100 EMERGENCY	0.251683			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.222538			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: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part II
Date/Time Prepared:
11/25/2019 4:38 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	1,019,242	148,833	870,409	0	0
53.00	05300	ANESTHESIOLOGY	17,227	3,127	14,100	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,112,176	135,850	1,976,326	0	0
60.00	06000	LABORATORY	1,502,955	90,372	1,412,583	0	0
65.00	06500	RESPIRATORY THERAPY	329,122	13,577	315,545	0	0
66.00	06600	PHYSICAL THERAPY	1,068,273	92,349	975,924	0	0
67.00	06700	OCCUPATIONAL THERAPY	253,873	14,018	239,855	0	0
68.00	06800	SPEECH PATHOLOGY	88,424	1,558	86,866	0	0
69.00	06900	ELECTROCARDIOLOGY	63,774	6,716	57,058	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	173,984	6,025	167,959	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,382	6,705	234,677	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,548,049	50,898	1,497,151	0	0
76.00	03610	BLANK	0	0	0	0	0
76.01	03550	SLEEP LAB	63,376	18,524	44,852	0	0
76.02	03020	PSYCH SERVICES	426,896	43,817	383,079	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,511,388	215,143	3,296,245	0	0
91.00	09100	EMERGENCY	3,340,626	124,456	3,216,170	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	456,547	35,322	421,225	0	0
200.00		Subtotal (sum of lines 50 thru 199)	16,217,314	1,007,290	15,210,024	0	0
201.00		Less Observation Beds	456,547	35,322	421,225	0	0
202.00		Total (line 200 minus line 201)	15,760,767	971,968	14,788,799	0	0

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

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part II
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	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	1,019,242	8,979,485	0.113508	50.00
53.00	05300	ANESTHESIOLOGY	17,227	255,718	0.067367	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,112,176	36,177,894	0.058383	54.00
60.00	06000	LABORATORY	1,502,955	28,359,142	0.052997	60.00
65.00	06500	RESPIRATORY THERAPY	329,122	1,974,801	0.166661	65.00
66.00	06600	PHYSICAL THERAPY	1,068,273	7,744,906	0.137932	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,873	2,504,691	0.101359	67.00
68.00	06800	SPEECH PATHOLOGY	88,424	458,117	0.193016	68.00
69.00	06900	ELECTROCARDIOLOGY	63,774	2,803,358	0.022749	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	173,984	2,658,872	0.065435	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	241,382	826,297	0.292125	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,548,049	5,597,758	0.276548	73.00
76.00	03610	BLANK	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	63,376	154,767	0.409493	76.01
76.02	03020	PSYCH SERVICES	426,896	128,599	3.319590	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,511,388	3,475,892	1.010212	88.00
91.00	09100	EMERGENCY	3,340,626	13,273,149	0.251683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	456,547	2,051,546	0.222538	92.00
200.00		Subtotal (sum of lines 50 thru 199)	16,217,314	117,424,992		200.00
201.00		Less Observation Beds	456,547	0		201.00
202.00		Total (line 200 minus line 201)	15,760,767	117,424,992		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared: 11/25/2019 4:38 pm	
					Title XVIII		Hospital	Cost
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	148,833	8,979,485	0.016575	424,665	7,039	50.00
53.00	05300	ANESTHESIOLOGY	3,127	255,718	0.012228	11,033	135	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,850	36,177,894	0.003755	1,092,115	4,101	54.00
60.00	06000	LABORATORY	90,372	28,359,142	0.003187	2,665,430	8,495	60.00
65.00	06500	RESPIRATORY THERAPY	13,577	1,974,801	0.006875	634,843	4,365	65.00
66.00	06600	PHYSICAL THERAPY	92,349	7,744,906	0.011924	657,865	7,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,018	2,504,691	0.005597	117,223	656	67.00
68.00	06800	SPEECH PATHOLOGY	1,558	458,117	0.003401	47,815	163	68.00
69.00	06900	ELECTROCARDIOLOGY	6,716	2,803,358	0.002396	102,907	247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,025	2,658,872	0.002266	751,418	1,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,705	826,297	0.008115	29,244	237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,898	5,597,758	0.009093	747,609	6,798	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	18,524	154,767	0.119690	0	0	76.01
76.02	03020	PSYCH SERVICES	43,817	128,599	0.340726	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	215,143	3,475,892	0.061896	0	0	88.00
91.00	09100	EMERGENCY	124,456	13,273,149	0.009377	32,199	302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	35,322	2,051,546	0.017217	9,686	167	92.00
200.00		Total (lines 50 through 199)	1,007,290	117,424,992		7,324,052	42,252	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 4:38 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 4:38 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	8,979,485	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	255,718	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,177,894	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,359,142	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,974,801	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,744,906	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,504,691	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	458,117	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,803,358	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,658,872	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	826,297	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,597,758	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	154,767	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	128,599	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,475,892	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	13,273,149	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,051,546	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	117,424,992		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 4:38 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	424,665	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	11,033	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,092,115	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	2,665,430	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	634,843	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	657,865	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	117,223	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	47,815	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	102,907	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	751,418	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	29,244	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	747,609	0	0	0 73.00
76.00	03610	BLANK	0.000000	0	0	0	0 76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0 76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
91.00	09100	EMERGENCY	0.000000	32,199	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	9,686	0	0	0 92.00
200.00		Total (lines 50 through 199)		7,324,052	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/25/2019 4:38 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	0.113508	0	2,633,885	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.067367	0	70,570	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.058383	0	11,363,535	0	0	54.00	
60.00	06000	LABORATORY	0.052997	0	8,692,922	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.166661	0	64,846	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.137932	0	1,235,263	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.101359	0	60,256	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.193016	0	5,895	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.022749	0	2,486,867	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.065435	0	224,761	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.292125	0	345,514	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276548	0	705,729	10,113	0	73.00	
76.00	03610	BLANK	0.000000	0	0	0	0	76.00	
76.01	03550	SLEEP LAB	0.409493	0	0	0	0	76.01	
76.02	03020	PSYCH SERVICES	3.319590	0	126,699	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
91.00	09100	EMERGENCY	0.251683	0	3,139,164	1,401	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.222538	0	767,427	0	0	92.00	
200.00		Subtotal (see instructions)		0	31,923,333	11,514	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	31,923,333	11,514	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/25/2019 4:38 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	298,967	0					50.00
53.00	05300	ANESTHESIOLOGY	4,754	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	663,437	0					54.00
60.00	06000	LABORATORY	460,699	0					60.00
65.00	06500	RESPIRATORY THERAPY	10,807	0					65.00
66.00	06600	PHYSICAL THERAPY	170,382	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	6,107	0					67.00
68.00	06800	SPEECH PATHOLOGY	1,138	0					68.00
69.00	06900	ELECTROCARDIOLOGY	56,574	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,707	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,933	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,168	2,797					73.00
76.00	03610	BLANK	0	0					76.00
76.01	03550	SLEEP LAB	0	0					76.01
76.02	03020	PSYCH SERVICES	420,589	0					76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
91.00	09100	EMERGENCY	790,074	353					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	170,782	0					92.00
200.00		Subtotal (see instructions)	3,365,118	3,150					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	3,365,118	3,150					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348

Period:

Worksheet D

Component CCN: 14-Z348

From 07/01/2018

Part V

To 06/30/2019

Date/Time Prepared:

11/25/2019 4:38 pm

			Title XVIII	Swing Beds - SNF		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	0.113508	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.067367	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.058383	0	0	0	0	54.00
60.00	06000	LABORATORY	0.052997	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.166661	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.137932	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101359	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.193016	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022749	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.065435	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.292125	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276548	0	0	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.409493	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	3.319590	0	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.251683	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.222538	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348

Period:

Worksheet D

Component CCN: 14-Z348

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/25/2019 4:38 pm

				Title XVIII	Swing Beds - SNF	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	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part I Date/Time Prepared: 11/25/2019 4:38 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		333,657	184,341	149,316	2,643	56.49	30.00	
200.00	Total (lines 30 through 199)		333,657		149,316	2,643		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		12	678					
200.00	Total (lines 30 through 199)		12	678					

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part II Date/Time Prepared: 11/25/2019 4:38 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		148,833	8,979,485	0.016575	0	0	50.00
53.00	05300	ANESTHESIOLOGY		3,127	255,718	0.012228	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		135,850	36,177,894	0.003755	0	0	54.00
60.00	06000	LABORATORY		90,372	28,359,142	0.003187	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		13,577	1,974,801	0.006875	0	0	65.00
66.00	06600	PHYSICAL THERAPY		92,349	7,744,906	0.011924	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		14,018	2,504,691	0.005597	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		1,558	458,117	0.003401	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		6,716	2,803,358	0.002396	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		6,025	2,658,872	0.002266	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		6,705	826,297	0.008115	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		50,898	5,597,758	0.009093	0	0	73.00
76.00	03610	BLANK		0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB		18,524	154,767	0.119690	0	0	76.01
76.02	03020	PSYCH SERVICES		43,817	128,599	0.340726	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		215,143	3,475,892	0.061896	0	0	88.00
91.00	09100	EMERGENCY		124,456	13,273,149	0.009377	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		35,648	2,051,546	0.017376	0	0	92.00
200.00		Total (lines 50 through 199)		1,007,616	117,424,992		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/25/2019 4:38 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	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	2,643	0.00	12			30.00	
200.00		Total (lines 30 through 199)	0	0	2,643		12			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: 14-1348		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 4:38 pm	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 4:38 pm

				Title XIX		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	8,979,485	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	255,718	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,177,894	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,359,142	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,974,801	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,744,906	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,504,691	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	458,117	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,803,358	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,658,872	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	826,297	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,597,758	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	154,767	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	128,599	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,475,892	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	13,273,149	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,051,546	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	117,424,992		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description			Title XIX		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
76.00	03610	BLANK	0.000000	0	0	0	0 76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0 76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 4:38 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)		6,157	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,643	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)		2,012	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		3,263	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		125	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)		126	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,359	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)		2,465	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		157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,312,629	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)		19,649	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)		19,806	25.00
26.00	Total swing-bed cost (see instructions)		2,400,333	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,912,296	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)		1,912,296	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)		723.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		983,277	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)		983,277	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/25/2019 4:38 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)					748,686 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,731,963 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)					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)					1,783,501 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,783,501 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)					631 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					723.53 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					456,547 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/25/2019 4:38 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	333,657	4,312,629	0.077367	456,547	35,322
91.00	Nursing School cost	0	4,312,629	0.000000	456,547	0
92.00	Allied health cost	0	4,312,629	0.000000	456,547	0
93.00	All other Medical Education	0	4,312,629	0.000000	456,547	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 4:38 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,157	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,643	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)		2,012	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		3,263	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		251	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		12	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,312,629	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		2,382,675	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,929,954	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)		1,929,954	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)		730.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,763	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)		8,763	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/25/2019 4:38 pm

		Title XIX		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,763	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)					678	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)					678	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,085	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					631	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					730.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					460,763	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description		Title XIX		Hospital	PPS	
		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	333,657	4,312,629	0.077367	460,763	35,648
91.00	Nursing School cost	0	4,312,629	0.000000	460,763	0
92.00	Allied health cost	0	4,312,629	0.000000	460,763	0
93.00	All other Medical Education	0	4,312,629	0.000000	460,763	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 4:38 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		4,494,858		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.113508	424,665	48,203	50.00
53.00	05300 ANESTHESIOLOGY	0.067367	11,033	743	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.058383	1,092,115	63,761	54.00
60.00	06000 LABORATORY	0.052997	2,665,430	141,260	60.00
65.00	06500 RESPIRATORY THERAPY	0.166661	634,843	105,804	65.00
66.00	06600 PHYSICAL THERAPY	0.137932	657,865	90,741	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.101359	117,223	11,882	67.00
68.00	06800 SPEECH PATHOLOGY	0.193016	47,815	9,229	68.00
69.00	06900 ELECTROCARDIOLOGY	0.022749	102,907	2,341	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.065435	751,418	49,169	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.292125	29,244	8,543	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276548	747,609	206,750	73.00
76.00	03610 BLANK	0.000000	0	0	76.00
76.01	03550 SLEEP LAB	0.409493	0	0	76.01
76.02	03020 PSYCH SERVICES	3.319590	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.251683	32,199	8,104	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.222538	9,686	2,156	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,324,052	748,686	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		7,324,052		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1348 Component CCN: 14-Z348	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 4:38 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		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.113508	51,522	5,848	50.00
53.00	05300 ANESTHESIOLOGY	0.067367	961	65	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.058383	270,884	15,815	54.00
60.00	06000 LABORATORY	0.052997	1,331,466	70,564	60.00
65.00	06500 RESPIRATORY THERAPY	0.166661	599,780	99,960	65.00
66.00	06600 PHYSICAL THERAPY	0.137932	2,243,528	309,454	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.101359	1,505,380	152,584	67.00
68.00	06800 SPEECH PATHOLOGY	0.193016	200,870	38,771	68.00
69.00	06900 ELECTROCARDIOLOGY	0.022749	44,422	1,011	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.065435	575,339	37,647	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.292125	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.276548	675,424	186,787	73.00
76.00	03610 BLANK	0.000000	0	0	76.00
76.01	03550 SLEEP LAB	0.409493	0	0	76.01
76.02	03020 PSYCH SERVICES	3.319590	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.251683	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.222538	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,499,576	918,506	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)		7,499,576		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 4:38 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,368,268	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		5,125,887	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)		3,368,268	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)		3,401,951	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)		5,125,887	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		24,551	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,611,175	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)		-1,233,775	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)		-1,233,775	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		-1,233,775	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)		525,091	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		341,309	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		501,358	36.00
37.00	Subtotal (see instructions)		-892,466	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)		-892,466	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		473,768	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-1,366,234	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/25/2019 4:38 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		1,157,983		473,768	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,157,983		473,768	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		195,029		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,366,234	6.02
7.00	Total Medicare program liability (see instructions)		1,353,012		-892,466	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: 14-1348

Period:

Worksheet E-1

Component CCN: 14-Z348

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:

11/25/2019 4:38 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,218,595		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,218,595		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		383,823		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,602,418		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: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/25/2019 4:38 pm	
		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1348 Component CCN: 14-Z348	Period: From 07/01/2018 To 06/30/2019	Worksheet E-2 Date/Time Prepared: 11/25/2019 4:38 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)	1,801,336	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, see instructions)	927,691	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	2,465	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,729,027	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,729,027	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,729,027	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	73,498	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,655,529	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,655,529	0	19.00
19.01	Sequestration adjustment (see instructions)	53,111	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	19.02
20.00	Interim payments	2,218,595	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	383,823	0	22.00
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
Comparision 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: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/25/2019 4:38 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,731,963	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,731,963	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,749,283	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,749,283	19.00
20.00	Deductibles (exclude professional component)		384,184	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,365,099	22.00
23.00	Coinsurance		335	23.00
24.00	Subtotal (line 22 minus line 23)		1,364,764	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		24,401	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		15,861	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,044	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,380,625	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,380,625	30.00
30.01	Sequestration adjustment (see instructions)		27,613	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,157,983	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		195,029	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet G

Date/Time Prepared:
11/25/2019 4:38 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	181,540	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	6,034,476	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,498,598	0	0	0	6.00
7.00	Inventory	454,465	0	0	0	7.00
8.00	Prepaid expenses	292,277	0	0	0	8.00
9.00	Other current assets	683,240	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,147,400	0	0	0	11.00
FIXED ASSETS						
12.00	Land	39,727	0	0	0	12.00
13.00	Land improvements	356,121	0	0	0	13.00
14.00	Accumulated depreciation	-165,951	0	0	0	14.00
15.00	Buildings	1,862,527	0	0	0	15.00
16.00	Accumulated depreciation	-1,389,623	0	0	0	16.00
17.00	Leasehold improvements	4,702,283	0	0	0	17.00
18.00	Accumulated depreciation	-2,002,866	0	0	0	18.00
19.00	Fixed equipment	2,579,956	0	0	0	19.00
20.00	Accumulated depreciation	-1,787,053	0	0	0	20.00
21.00	Automobiles and trucks	34,042	0	0	0	21.00
22.00	Accumulated depreciation	-34,042	0	0	0	22.00
23.00	Major movable equipment	4,203,987	0	0	0	23.00
24.00	Accumulated depreciation	-3,432,266	0	0	0	24.00
25.00	Minor equipment depreciable	2,980,478	0	0	0	25.00
26.00	Accumulated depreciation	-2,617,510	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,329,810	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	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	1,276,480	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,276,480	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,753,690	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,016,582	0	0	0	37.00
38.00	Salaries, wages, and fees payable	882,175	0	0	0	38.00
39.00	Payroll taxes payable	123,234	0	0	0	39.00
40.00	Notes and loans payable (short term)	16,225	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	-9,403,741	0	0	0	43.00
44.00	Other current liabilities	530,657	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-5,834,868	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-5,834,868	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	18,588,558				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)	18,588,558	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,753,690	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-1

Date/Time Prepared:
11/25/2019 4:38 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		15,369,699		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,218,858				2.00
3.00	Total (sum of line 1 and line 2)		18,588,557		0		3.00
4.00	ROUNDING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,588,558		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)		18,588,558		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	ROUNDING		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: 14-1348

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2019 4:38 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,542,024		12,542,024	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	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)	12,542,024		12,542,024	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)	12,542,024		12,542,024	17.00
18.00	Ancillary services	24,932,353	0	24,932,353	18.00
19.00	Outpatient services	0	89,016,747	89,016,747	19.00
20.00	RURAL HEALTH CLINIC	0	3,475,892	3,475,892	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	6,093,556	6,093,556	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	37,474,377	98,586,195	136,060,572	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,427,127		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)		25,427,127		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1348

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-3

Date/Time Prepared:
11/25/2019 4:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	136,060,572	1.00
2.00	Less contractual allowances and discounts on patients' accounts	107,642,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,418,572	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,427,127	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,991,445	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	227,413	24.00
25.00	Total other income (sum of lines 6-24)	227,413	25.00
26.00	Total (line 5 plus line 25)	3,218,858	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)	3,218,858	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/25/2019 4:38 pm
		Title XVIII	Hospital	Cost
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		0	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		0.00	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		0	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348

Period:

Worksheet M-1

Component CCN: 14-8514

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 4:38 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,015,280	0	1,015,280	0	1,015,280	1.00
2.00	Physician Assistant	31,799	0	31,799	0	31,799	2.00
3.00	Nurse Practitioner	487,045	0	487,045	0	487,045	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	285,877	0	285,877	0	285,877	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	110,898	81,164	192,062	63,325	255,387	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,930,899	81,164	2,012,063	63,325	2,075,388	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	74,884	74,884	0	74,884	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	51,008	51,008	-51,008	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	125,892	125,892	-51,008	74,884	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,930,899	207,056	2,137,955	12,317	2,150,272	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	42,108	42,108	-42,108	0	29.00
30.00	Administrative Costs	291,855	231,812	523,667	-52,943	470,724	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	291,855	273,920	565,775	-95,051	470,724	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,222,754	480,976	2,703,730	-82,734	2,620,996	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348

Period:

Worksheet M-1

Component CCN: 14-8514

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 4:38 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	-408,658	606,622	1.00
2.00	Physician Assistant	0	31,799	2.00
3.00	Nurse Practitioner	-15,664	471,381	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	285,877	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	-55,499	199,888	9.00
10.00	Subtotal (sum of lines 1 through 9)	-479,821	1,595,567	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	74,884	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	74,884	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-479,821	1,670,451	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	0	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			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-35,531	435,193	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-35,531	435,193	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-515,352	2,105,644	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1348 Component CCN: 14-8514		Period: From 07/01/2018 To 06/30/2019		Worksheet M-2 Date/Time Prepared: 11/25/2019 4:38 pm	
			RHC I		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4			
	1.00	2.00	3.00	4.00	5.00			
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	1.27	4,099	4,200	5,334			1.00
2.00	Physician Assistant	0.18	452	2,100	378			2.00
3.00	Nurse Practitioner	3.06	6,357	2,100	6,426			3.00
4.00	Subtotal (sum of lines 1 through 3)	4.51	10,908		12,138		12,138	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)	4.51	10,908				12,138	8.00
9.00	Physician Services Under Agreements		0				0	9.00
							1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES								
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)						1,670,451	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						1,670,451	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						435,193	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						1,405,744	15.00
16.00	Total overhead (sum of lines 14 and 15)						1,840,937	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						1,840,937	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						1,840,937	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						3,511,388	20.00

Health Financial Systems		RED BUD REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1348	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-8514		Date/Time Prepared: 11/25/2019 4:38 pm	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,511,388	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			24,457	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,486,931	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,138	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)			12,138	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			287.27	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.36	84.36	8.00
9.00	Rate for Program covered visits (see instructions)		287.27	287.27	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		3,138	3,138	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		901,453	901,453	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,802,906	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,276,778	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			84,190	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			118,882	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.)			1,274,157	16.04
16.05	Total program cost (see instructions)		0	1,393,039	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			91,328	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			220,252	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,393,039	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			14,825	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,407,864	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)			1,407,864	26.00
26.01	Sequestration adjustment (see instructions)			28,157	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,067,551	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)			312,156	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 4:38 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,595,567	1,595,567	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000459	0.001322	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		732	2,109	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,903	2,891	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		6,635	5,000	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,670,451	1,670,451	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,840,937	1,840,937	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003972	0.002993	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,312	5,510	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		13,947	10,510	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		115	331	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		121.28	31.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		67	211	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		8,126	6,699	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			24,457	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			14,825	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 4:38 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		1,067,551	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,067,551	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		312,156	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,379,707	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00