

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: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/30/2020 10:45 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/30/2020	Time: 10:45 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENVILLE REGIONAL HOSPITAL (14-0137) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	72,110	6,159	0	0	1.00
2.00	Subprovider - IPF	0	3,053	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	966	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		131,992		0	10.00
200.00	Total	0	76,129	138,151	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: 14-0137		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 10:45 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 200 HEALTHCARE DRIVE			PO Box:						1.00		
2.00	City: GREENVILLE			State: IL		Zip Code: 62246-1156		County: BOND			2.00	
				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			GREENVILLE REGIONAL HOSPITAL	140137	41180	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF			GREENVILLE I/P PSYCH UNIT	14S137	41180	4	01/01/2005	N	P	N	4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			GREENVILLE REGIONAL HOSP- SWING BED	14U137	41180		10/03/2001	N	P	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC			HSBS HOLY FAMILY HEALTH CENTER-MOB C	148519	41180		07/24/2007	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
								From:	To:			
								1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)							07/01/2019	06/30/2020		20.00	
21.00	Type of Control (see instructions)							2			21.00	
								1.00	2.00	3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	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)						Y	Y			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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/30/2020 10:45 am

	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.	9	44	0	0	162	69	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		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.					1		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 OPSS 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)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0137		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 10:45 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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	0.000000

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00

Health Financial Systems		GREENVILLE REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 10:45 am			
			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.			N	86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00		
			V	XIX			
			1.00	2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	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?			N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00	
			Physical	Occupational	Speech	Respiratory	
			1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
			1.00				
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 10:45 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	48,016	0	646,638 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	148005	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 10:45 am
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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: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131		141.00
142.00	Street: 4936 LAVERNA ROAD	PO Box:				142.00
143.00	City: SPRINGFIELD	State: IL		Zip Code: 62794		143.00
						1.00
144.00 Are provider based physicians' costs included in Worksheet A?						Y
						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.					
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N
						1.00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
						1.00
Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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)					41180
						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
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					
168.01	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)					
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
				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)					
				1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N
						0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/30/2020 10:45 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/26/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/30/2020 10:45 am

		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.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/30/2020 10:45 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 10:45 am

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	28	10,616	0.00	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)		28	10,616	0.00	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	43.00				0	13.00
14.00 Total (see instructions)		28	10,616	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		38				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: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 10:45 am

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)	796	9	1,326			1.00
2.00	HMO and other (see instructions)	84	162				2.00
3.00	HMO IPF Subprovider	30	87				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	557	0	729			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	214			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,353	9	2,269			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		44	61			13.00
14.00	Total (see instructions)	1,353	53	2,330	0.00	125.12	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,076	0	1,547	0.00	11.95	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	3,411	186	9,806	0.00	20.20	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	157.27	27.00
28.00	Observation Bed Days		4	276			28.00
29.00	Ambulance Trips	512					29.00
30.00	Employee discount days (see instruction)			11			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	69	96			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: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 10:45 am

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	237	3	484	1.00
2.00 HMO and other (see instructions)			31	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	237	3	484	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	65	0	105	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/30/2020 10:45 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	8,989,761	0	8,989,761	327,190.00	27.48
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		356,889	0	356,889	3,385.47	105.42
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		92,867	0	92,867	1,664.00	55.81
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,514,204	1,290	1,515,494	35,517.86	42.67
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,208,326	0	1,208,326	17,121.00	70.58
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		32,285	0	32,285	293.66	109.94
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,478,230	0	1,478,230	44,741.89	33.04
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,598,275	0	2,598,275		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		420,774	0	420,774		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		72,646	0	72,646		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		23,062	0	23,062		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		665,428	0	665,428		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/30/2020 10:45 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,511,537	-9,015	1,502,522	57,828.47	25.98	27.00
28.00	Administrative & General under contract (see inst.)		185,818	0	185,818	3,308.68	56.16	28.00
29.00	Maintenance & Repairs	6.00	284,352	27	284,379	10,069.91	28.24	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	267,981	0	267,981	20,814.95	12.87	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	273,915	-114,970	158,945	9,747.62	16.31	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	114,970	114,970	8,432.23	13.63	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	339,318	0	339,318	7,247.21	46.82	38.00
39.00	Central Services and Supply	14.00	113,881	289	114,170	4,661.31	24.49	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	4	138	142	8,598.01	0.02	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
11/30/2020 10:45 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	8,725,823	0	8,725,823	325,449.21	26.81	1.00
2.00	Excluded area salaries (see instructions)	1,514,204	1,290	1,515,494	35,517.86	42.67	2.00
3.00	Subtotal salaries (line 1 minus line 2)	7,211,619	-1,290	7,210,329	289,931.35	24.87	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,718,841	0	2,718,841	62,156.55	43.74	4.00
5.00	Subtotal wage-related costs (see inst.)	3,263,703	0	3,263,703	0.00	45.26	5.00
6.00	Total (sum of lines 3 thru 5)	13,194,163	-1,290	13,192,873	352,087.90	37.47	6.00
7.00	Total overhead cost (see instructions)	2,976,806	-8,561	2,968,245	130,708.39	22.71	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2020 10:45 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		291,040	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)		430,366	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		2,844	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)		1,552,426	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		42,151	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		59,188	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)		12,160	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		136,799	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		458,365	17.00
18.00	Medicare Taxes - Employers Portion Only		130,351	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		-4,500	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		3,568	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		3,114,758	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	4,205,550	3,114,758	1.00
2.00	Hospital	1,208,326	3,114,758	2.00
3.00	Subprovider - IPF	78,596	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	2,918,628	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		GREENVILLE REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0137 Component CCN: 14-8519		Period: From 07/01/2019 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 11/30/2020 10:45 am	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	201 HEALTHCARE DRIVE 1.00			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GREENVILLE		IL 62246	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)	4.00			
5.00	Migrant Health Center (Section 329(d), PHS Act)	5.00			
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	6.00			
7.00	Appalachian Regional Commission	7.00			
8.00	Look-Alikes	8.00			
9.00	OTHER (SPECIFY)	9.00			
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	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.	Y		4	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number	HSHS HOLY FAMILY HEALTH CENTER-MOB C		148519	14.00
14.01		HSHS HOLY FAMILY HEALTH CENTER-POCAH		148520	14.01
14.02		HSHS HOLY FAMILY HEALTH CENTER-MOB A		148513	14.02
14.03		HSHS HOLY FAMILY HEALTH CENTER-CONVE		148545	14.03
		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)				
		Total Visits			
		1.00		2.00	3.00
		4.00		5.00	
		15.00			

MCRIF32 - 16.4.169.5

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-10

Date/Time Prepared:
11/30/2020 10:45 am

				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)			0.426069	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			1,052,415	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			1,176,000	5.00
6.00	Medicaid charges			9,421,661	6.00
7.00	Medicaid cost (line 1 times line 6)			4,014,278	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,785,863	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,785,863	19.00
				Uninsured patients	Insured patients
				1.00	2.00
				Total (col. 1 + col. 2)	
				3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)			264,652	277,716
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)			112,760	277,716
22.00	Payments received from patients for amounts previously written off as charity care			0	0
23.00	Cost of charity care (line 21 minus line 22)			112,760	277,716
				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	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,973,246	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			33,606	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			51,701	
28.00	Non-Medicare bad debt expense (see instructions)			1,921,545	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			836,806	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,227,282	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,013,145	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/30/2020 10:45 am

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		1,483,518	1,483,518	-589,857	893,661	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		577,829	577,829	740,745	1,318,574	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,769,148	2,769,148	1,020,007	3,789,155	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,511,537	5,587,655	7,099,192	-1,055,078	6,044,114	5.00
6.00	00600	MAINTENANCE & REPAIRS	284,352	980,073	1,264,425	27	1,264,452	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,812	102,812	0	102,812	8.00
9.00	00900	HOUSEKEEPING	267,981	178,894	446,875	0	446,875	9.00
10.00	01000	DIETARY	273,915	266,900	540,815	-214,050	326,765	10.00
11.00	01100	CAFETERIA	0	0	0	214,050	214,050	11.00
13.00	01300	NURSING ADMINISTRATION	339,318	106,073	445,391	0	445,391	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,881	18,554	132,435	289	132,724	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4	1,683,635	1,683,639	138	1,683,777	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	519,857	519,857	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,091,041	1,423,188	2,514,229	-149,666	2,364,563	30.00
40.00	04000	SUBPROVIDER - IPF	648,961	277,567	926,528	721	927,249	40.00
43.00	04300	NURSERY	0	0	0	124,995	124,995	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	465,388	225,983	691,371	25,336	716,707	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	26,811	26,811	52.00
53.00	05300	ANESTHESIOLOGY	356,889	185,482	542,371	-542,371	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	534,041	388,925	922,966	265	923,231	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	575,553	656,595	1,232,148	309	1,232,457	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	277,112	21,817	298,929	-66,455	232,474	65.00
66.00	06600	PHYSICAL THERAPY	0	1,103,003	1,103,003	-328,152	774,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	239,540	239,540	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	88,612	88,612	68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,665	47,665	67,105	114,770	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	198,986	198,986	0	198,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,395	42,395	0	42,395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	405,083	578,067	983,150	490	983,640	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	6,429	1,027	7,456	0	7,456	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	129,759	3,112,737	3,242,496	0	3,242,496	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	843,274	1,323,772	2,167,046	595	2,167,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	625,818	45,044	670,862	0	670,862	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		124,832	124,832	-124,832	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,750,336	23,512,176	32,262,512	-569	32,261,943	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	139,527	824,071	963,598	569	964,167	192.00
193.00	19300	NONPAID WORKERS	34,182	22,418	56,600	0	56,600	193.00
194.00	07950	EMERALD POINT	65,716	171,692	237,408	0	237,408	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	8,989,761	24,530,357	33,520,118	0	33,520,118	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-148,653	745,008	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-111	1,318,463	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-729,949	3,059,206	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-407,580	5,636,534	5.00
6.00	00600	MAINTENANCE & REPAIRS	-14,855	1,249,597	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-11,070	91,742	8.00
9.00	00900	HOUSEKEEPING	0	446,875	9.00
10.00	01000	DIETARY	0	326,765	10.00
11.00	01100	CAFETERIA	-48,717	165,333	11.00
13.00	01300	NURSING ADMINISTRATION	-2,335	443,056	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	132,724	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-271,812	1,411,965	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-519,857	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,155,359	1,209,204	30.00
40.00	04000	SUBPROVIDER - IPF	-197,362	729,887	40.00
43.00	04300	NURSERY	0	124,995	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-134,200	582,507	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,811	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,467	920,764	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-10,074	1,222,383	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	232,474	65.00
66.00	06600	PHYSICAL THERAPY	0	774,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	239,540	67.00
68.00	06800	SPEECH PATHOLOGY	0	88,612	68.00
69.00	06900	ELECTROCARDIOLOGY	-36,632	78,138	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-91	198,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-179	983,461	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	7,456	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	260,568	3,503,064	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,249,297	918,344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-5,193	665,669	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,685,225	27,576,718	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	23,947	988,114	192.00
193.00	19300	NONPAID WORKERS	0	56,600	193.00
194.00	07950	EMERALD POINT	3,382	240,790	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,657,896	28,862,222	200.00

RECLASSIFICATIONS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/30/2020 10:45 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CRNA FEES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	356,889	162,968		1.00
2.00	OPERATING ROOM	50.00	0	22,514		2.00
	0		356,889	185,482		
	B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	114,970	99,080		1.00
	0		114,970	99,080		
	C - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	734,585		1.00
	0		0	734,585		
	D - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	67,105	0		1.00
	0		67,105	0		
	E - OB EXPENSE					
1.00	NURSERY	43.00	60,906	64,089		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	13,064	13,747		2.00
	0		73,970	77,836		
	F - CONTRACT THERAPY EXPENSE					
1.00	OCCUPATIONAL THERAPY	67.00	0	239,540		1.00
2.00	SPEECH PATHOLOGY	68.00	0	88,612		2.00
	0		0	328,152		
	G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	26,056		1.00
	0		0	26,056		
	H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	124,832		1.00
	0		0	124,832		
	I - COVID EXPENSE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,020,007		1.00
2.00	MAINTENANCE & REPAIRS	6.00	27	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	289	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	138	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	2,140	0		5.00
6.00	SUBPROVIDER - IPF	40.00	721	0		6.00
7.00	OPERATING ROOM	50.00	2,822	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	265	0		8.00
9.00	LABORATORY	60.00	309	0		9.00
10.00	RESPIRATORY THERAPY	65.00	650	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	490	0		11.00
12.00	EMERGENCY	91.00	595	0		12.00
13.00	PHYSICIANS PRIVATE OFFICES	192.00	569	0		13.00
	TOTALS		9,015	1,020,007		
500.00	Grand Total: Increases		621,949	2,596,030		500.00

RECLASSIFICATIONS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
11/30/2020 10:45 am

		Decreases				Wkst. A-7 Ref.	
		Cost Center	Line #	Salary	Other		
		6.00	7.00	8.00	9.00	10.00	
A - CRNA FEES							
1.00		ANESTHESIOLOGY	53.00	356,889	185,482	0	1.00
2.00			0.00	0	0	0	2.00
		0		356,889	185,482		
B - CAFETERIA EXPENSE							
1.00		DIETARY	10.00	114,970	99,080	0	1.00
		0		114,970	99,080		
C - DEPRECIATION EXPENSE							
1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	734,585	9	1.00
		0		0	734,585		
D - EKG SALARIES							
1.00		RESPIRATORY THERAPY	65.00	67,105	0	0	1.00
		0		67,105	0		
E - OB EXPENSE							
1.00		ADULTS & PEDIATRICS	30.00	73,970	77,836	0	1.00
2.00			0.00	0	0	0	2.00
		0		73,970	77,836		
F - CONTRACT THERAPY EXPENSE							
1.00		PHYSICAL THERAPY	66.00	0	328,152	0	1.00
2.00			0.00	0	0	0	2.00
		0		0	328,152		
G - PROPERTY INSURANCE							
1.00		ADMINISTRATIVE & GENERAL	5.00	0	26,056	12	1.00
		0		0	26,056		
H - INTEREST EXPENSE							
1.00		INTEREST EXPENSE	113.00	0	124,832	11	1.00
		0		0	124,832		
I - COVID EXPENSE RECLASS							
1.00		ADMINISTRATIVE & GENERAL	5.00	9,015	1,020,007	0	1.00
2.00			0.00	0	0	0	2.00
3.00			0.00	0	0	0	3.00
4.00			0.00	0	0	0	4.00
5.00			0.00	0	0	0	5.00
6.00			0.00	0	0	0	6.00
7.00			0.00	0	0	0	7.00
8.00			0.00	0	0	0	8.00
9.00			0.00	0	0	0	9.00
10.00			0.00	0	0	0	10.00
11.00			0.00	0	0	0	11.00
12.00			0.00	0	0	0	12.00
13.00			0.00	0	0	0	13.00
		TOTALS		9,015	1,020,007		
500.00		Grand Total: Decreases		621,949	2,596,030		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/30/2020 10:45 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,540,441	0	0	0	0	1.00	
2.00	Land Improvements	406,675	0	0	0	0	2.00	
3.00	Buildings and Fixtures	7,114,752	400,042	0	400,042	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	1,884,997	228,817	0	228,817	0	6.00	
7.00	HIT designated Assets	815,874	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	11,762,739	628,859	0	628,859	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	11,762,739	628,859	0	628,859	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,540,441	0				1.00	
2.00	Land Improvements	406,675	0				2.00	
3.00	Buildings and Fixtures	7,514,794	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	2,113,814	0				6.00	
7.00	HIT designated Assets	815,874	0				7.00	
8.00	Subtotal (sum of lines 1-7)	12,391,598	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	12,391,598	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/30/2020 10:45 am

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	1,398,769	72,829	0	0	11,920	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	577,829	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,398,769	650,658	0	0	11,920	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	1,483,518				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	577,829				2.00
3.00	Total (sum of lines 1-2)	0	2,061,347				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/30/2020 10:45 am

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	9,461,910	0	9,461,910	0.763575	19,896	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,929,688	0	2,929,688	0.236425	6,160	2.00
3.00	Total (sum of lines 1-2)	12,391,598	0	12,391,598	1.000000	26,056	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	19,896	522,619	72,829	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,160	734,474	577,829	2.00
3.00	Total (sum of lines 1-2)	0	0	26,056	1,257,093	650,658	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	117,744	19,896	11,920	0	745,008	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,160	0	0	1,318,463	2.00
3.00	Total (sum of lines 1-2)	117,744	26,056	11,920	0	2,063,471	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/30/2020 10:45 am

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		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-7,088	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	B	-14,855	MAINTENANCE & REPAIRS	6.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,829,901			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,010,360			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-47,644	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-91	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,027	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-893	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-519,857	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CRNA RELATED BENEFITS	A	-31,543	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
11/30/2020 10:45 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 RESTRUCTURING EXPENSE	A	-135,572	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 LOBBYING EXPENSE	A	-9,331	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 ADVERTISING OFFSET	A	-66,559	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 AMBULANCE REIMBURSEMENT	B	-5,193	AMBULANCE SERVICES	95.00	0	33.04
33.05 EDUCATION SEMINARS	B	-2,335	NURSING ADMINISTRATION	13.00	0	33.05
33.06 PROVIDER TAX	A	-1,088,172	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.08 HEALTH FAIR EXP ADJ	A	-10,074	LABORATORY	60.00	0	33.08
33.09 MISC REVENUE	B	-1,884	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 SELF INSURANCE ADJUSTMENT	A	-832,581	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11 RENT	B	-2,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.13 TELEPHONE SERVICE	A	-111	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.13
33.14 TELEPHONE SERVICE	A	-4,592	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15 TELEPHONE SERVICE	A	-683	CAP REL COSTS-BLDG & FIXT	1.00	9	33.15
33.16 CATERING REVENUE	B	-180	CAFETERIA	11.00	0	33.16
33.18 MISC SUPPLY REVENUE	B	-179	DRUGS CHARGED TO PATIENTS	73.00	0	33.18
33.19 REVALUED ASSETS DEPRECIATION	A	-175,015	CAP REL COSTS-BLDG & FIXT	1.00	9	33.19
33.20 REVALUED ASSETS DEPRECIATION	A	23,947	PHYSICIANS PRIVATE OFFICES	192.00	0	33.20
33.21 REVALUED ASSETS DEPRECIATION	A	3,382	EMERALD POINT	194.00	0	33.21
33.22 ALCHOLIC BEVERAGES	A	-323	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23 FOOD COSTS FOR ADMINISTRATION	A	-335	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24 DEFINED PENSION	A	133,274	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25 PHYSICIAN RECRUITMENT	A	-315	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26 PHYSICIAN RECRUITMENT	A	-40,526	ADMINISTRATIVE & GENERAL	5.00	0	33.26
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,657,896				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: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:

11/30/2020 10:45 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	GFW RHC LEASE EXPENSE	6,897	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	GMA RHC LEASE EXPENSE	10,345	979	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	MDH RHC LEASE EXPENSE	13,793	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	MDH POKEY RHC LEASE EXPENSE	4,077	0	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUM	2,102,352	2,101,136	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HSBS HOME OFFICE ALLOCATIONS	936,571	459,516	4.02
4.03	88.00	RURAL HEALTH CLINIC	RHC MANAGEMENT FEES	260,568	0	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	SBO FEE	1,324,214	1,594,999	4.04
4.05	8.00	LAUNDRY & LINEN SERVICE	CID - LAUNDRY	87,774	98,844	4.05
4.06	73.00	DRUGS CHARGED TO PATIENTS	SID - SHARED PHARMACIST	47,648	47,648	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SID - A&G	523,168	3,925	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			5,317,407	4,307,047	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		
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	HSBS	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: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/30/2020 10:45 am

	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	6,897	9		1.00
2.00	9,366	9		2.00
3.00	13,793	9		3.00
4.00	4,077	9		4.00
4.01	1,216	0		4.01
4.02	477,055	0		4.02
4.03	260,568	0		4.03
4.04	-270,785	0		4.04
4.05	-11,070	0		4.05
4.06	0	0		4.06
4.07	519,243	0		4.07
5.00	1,010,360			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	CORP OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
11/30/2020 10:45 am

	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	54.00	RADIOLOGY-DIAGNOSTIC	467	467	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	36,632	36,632	0	0	0	2.00
3.00	91.00	EMERGENCY	1,249,297	1,249,297	0	0	0	3.00
4.00	60.00	LABORATORY	28,484	0	28,484	260,300	268	4.00
5.00	40.00	SUBPROVIDER - IPF	199,628	195,827	3,801	181,300	26	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	56,584	56,584	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	1,155,359	1,155,359	0	0	0	7.00
8.00	50.00	OPERATING ROOM	134,200	134,200	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,860,651	2,828,366	32,285		294	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	33,539	1,677	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	2,266	113	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			35,805	1,790	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	467		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	36,632		2.00
3.00	91.00	EMERGENCY	0	0	0	1,249,297		3.00
4.00	60.00	LABORATORY	0	33,539	0	0		4.00
5.00	40.00	SUBPROVIDER - IPF	0	2,266	1,535	197,362		5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	56,584		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,155,359		7.00
8.00	50.00	OPERATING ROOM	0	0	0	134,200		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	35,805	1,535	2,829,901		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
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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	745,008	745,008			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,318,463		1,318,463		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,059,206	903	1,598	3,061,707	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,636,534	196,142	347,123	532,879	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,249,597	61,944	109,624	100,857	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,742	10,802	19,117	0	8.00
9.00	00900	HOUSEKEEPING	446,875	10,022	17,736	95,041	9.00
10.00	01000	DIETARY	326,765	18,857	33,372	56,371	10.00
11.00	01100	CAFETERIA	165,333	5,251	9,292	40,775	11.00
13.00	01300	NURSING ADMINISTRATION	443,056	10,959	19,394	120,342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,724	34,905	61,772	40,491	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,411,965	13,194	23,349	50	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,209,204	46,298	81,935	340,387	30.00
40.00	04000	SUBPROVIDER - IPF	729,887	25,005	44,252	230,414	40.00
43.00	04300	NURSERY	124,995	11,416	20,203	18,743	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	582,507	44,587	78,906	166,054	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,811	2,676	4,735	28,575	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	920,764	32,614	57,717	189,495	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,222,383	14,147	25,036	204,233	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	232,474	8,043	14,235	74,711	65.00
66.00	06600	PHYSICAL THERAPY	774,851	24,292	42,990	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,540	7,765	13,741	0	67.00
68.00	06800	SPEECH PATHOLOGY	88,612	2,854	5,051	0	68.00
69.00	06900	ELECTROCARDIOLOGY	78,138	713	1,263	23,799	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	198,895	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,395	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	983,461	5,786	10,239	143,839	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	7,456	2,207	3,906	2,280	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,503,064	98,131	173,665	46,020	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	918,344	12,731	22,531	299,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	665,669	11,867	21,002	221,951	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,576,718	714,111	1,263,784	2,976,591	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	988,114	27,809	49,214	49,686	192.00
193.00	19300	NONPAID WORKERS	56,600	3,088	5,465	12,123	193.00
194.00	07950	EMERALD POINT	240,790	0	0	23,307	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	28,862,222	745,008	1,318,463	3,061,707	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,712,678					5.00
6.00	00600	MAINTENANCE & REPAIRS	461,267	1,983,289				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,871	44,082	202,614			8.00
9.00	00900	HOUSEKEEPING	172,647	40,897	0	783,218		9.00
10.00	01000	DIETARY	131,943	76,950	0	31,748	676,006	10.00
11.00	01100	CAFETERIA	66,871	21,427	0	8,840	0	11.00
13.00	01300	NURSING ADMINISTRATION	179,943	44,719	0	18,450	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	81,794	142,435	0	58,767	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	439,003	53,840	0	22,214	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	508,485	188,928	114,613	77,949	318,273	30.00
40.00	04000	SUBPROVIDER - IPF	312,020	102,038	74,624	42,100	88,339	40.00
43.00	04300	NURSERY	53,144	46,584	2,943	19,220	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	264,286	181,945	0	75,068	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,031	10,918	0	4,505	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	363,853	133,087	0	54,910	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	444,228	57,729	0	23,818	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	99,848	32,822	0	13,542	0	65.00
66.00	06600	PHYSICAL THERAPY	255,219	99,127	8,502	40,898	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	79,113	31,685	0	13,073	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,251	11,646	0	4,805	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,492	2,911	0	1,201	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	60,278	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,848	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	346,498	23,610	0	9,741	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	4,803	9,007	0	3,716	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,157,957	400,443	1,824	165,219	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	379,703	51,952	0	21,435	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	278,965	48,426	0	19,980	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,271,361	1,857,208	202,506	731,199	406,612	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	337,860	113,480	0	46,820	0	192.00
193.00	19300	NONPAID WORKERS	23,419	12,601	0	5,199	0	193.00
194.00	07950	EMERALD POINT	80,038	0	108	0	269,394	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,712,678	1,983,289	202,614	783,218	676,006	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	317,789					11.00
13.00	01300	NURSING ADMINISTRATION	10,617	847,480				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,829	0	559,717			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,597	0	0	1,976,212		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,402	234,976	17,195	78,791	0	30.00
40.00	04000	SUBPROVIDER - IPF	36,492	212,234	3,534	66,480	0	40.00
43.00	04300	NURSERY	3,037	17,663	505	2,072	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,050	0	38,195	78,626	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,587	0	769	2,578	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	898	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,936	0	37,461	632,218	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	31,325	0	184,225	405,774	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	10,194	0	9,755	52,813	0	65.00
66.00	06600	PHYSICAL THERAPY	17,799	0	4,446	144,142	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,852	0	0	23,803	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,121	0	0	5,655	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,774	0	0	30,452	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	110,500	29,202	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	23,532	9,480	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,079	0	0	170,638	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	1,108	0	566	4,827	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,661	0	68,879	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	65,784	382,607	20,997	170,208	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	12,595	67,555	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	302,244	847,480	533,154	1,976,212	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	9,182	0	5,033	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	1,088	0	0	193.00
194.00	07950	EMERALD POINT	6,363	0	20,442	0	0	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
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)	317,789	847,480	559,717	1,976,212	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 10:45 am

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
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,257,436	0	3,257,436	30.00
40.00	04000	SUBPROVIDER - IPF	1,967,419	0	1,967,419	40.00
43.00	04300	NURSERY	320,525	0	320,525	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,526,224	0	1,526,224	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	105,185	0	105,185	52.00
53.00	05300	ANESTHESIOLOGY	898	0	898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,446,055	0	2,446,055	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	2,612,898	0	2,612,898	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	548,437	0	548,437	65.00
66.00	06600	PHYSICAL THERAPY	1,412,266	0	1,412,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	411,572	0	411,572	67.00
68.00	06800	SPEECH PATHOLOGY	148,995	0	148,995	68.00
69.00	06900	ELECTROCARDIOLOGY	173,743	0	173,743	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	398,875	0	398,875	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,255	0	88,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,704,891	0	1,704,891	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	39,876	0	39,876	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,617,863	0	5,617,863	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	2,345,576	0	2,345,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,348,010	0	1,348,010	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,474,999	0	26,474,999	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,627,198	0	1,627,198	192.00
193.00	19300	NONPAID WORKERS	119,583	0	119,583	193.00
194.00	07950	EMERALD POINT	640,442	0	640,442	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	194.01
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)	28,862,222	0	28,862,222	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/30/2020 10:45 am

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	903	1,598	2,501	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,605	196,142	347,123	557,870	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	61,944	109,624	171,568	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,802	19,117	29,919	8.00
9.00	00900	HOUSEKEEPING	0	10,022	17,736	27,758	9.00
10.00	01000	DIETARY	0	18,857	33,372	52,229	10.00
11.00	01100	CAFETERIA	0	5,251	9,292	14,543	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,959	19,394	30,353	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,905	61,772	96,677	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,194	23,349	36,543	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	46,298	81,935	128,233	30.00
40.00	04000	SUBPROVIDER - IPF	0	25,005	44,252	69,257	40.00
43.00	04300	NURSERY	0	11,416	20,203	31,619	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	44,587	78,906	123,493	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,676	4,735	7,411	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,614	57,717	90,331	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	14,147	25,036	39,183	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	8,043	14,235	22,278	65.00
66.00	06600	PHYSICAL THERAPY	0	24,292	42,990	67,282	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,765	13,741	21,506	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,854	5,051	7,905	68.00
69.00	06900	ELECTROCARDIOLOGY	0	713	1,263	1,976	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	5,786	10,239	16,025	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	2,207	3,906	6,113	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	98,131	173,665	271,796	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	12,731	22,531	35,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	11,867	21,002	32,869	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,605	714,111	1,263,784	1,992,500	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	27,809	49,214	77,023	192.00
193.00	19300	NONPAID WORKERS	0	3,088	5,465	8,553	193.00
194.00	07950	EMERALD POINT	77,473	0	0	77,473	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
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)	92,078	745,008	1,318,463	2,155,549	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	558,305					5.00
6.00	00600	MAINTENANCE & REPAIRS	38,364	210,014				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,067	4,668	37,654			8.00
9.00	00900	HOUSEKEEPING	14,359	4,331	0	46,526		9.00
10.00	01000	DIETARY	10,974	8,148	0	1,886	73,283	10.00
11.00	01100	CAFETERIA	5,562	2,269	0	525	0	11.00
13.00	01300	NURSING ADMINISTRATION	14,966	4,735	0	1,096	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,803	15,083	0	3,491	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,512	5,701	0	1,320	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,291	20,006	21,300	4,630	34,503	30.00
40.00	04000	SUBPROVIDER - IPF	25,951	10,805	13,868	2,501	9,576	40.00
43.00	04300	NURSERY	4,420	4,933	547	1,142	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,981	19,266	0	4,459	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,583	1,156	0	268	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,262	14,093	0	3,262	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	36,947	6,113	0	1,415	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,304	3,476	0	804	0	65.00
66.00	06600	PHYSICAL THERAPY	21,227	10,497	1,580	2,430	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,580	3,355	0	777	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,433	1,233	0	285	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,619	308	0	71	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	5,013	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,069	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,819	2,500	0	579	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	399	954	0	221	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	96,313	42,404	339	9,814	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	31,580	5,501	0	1,273	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	23,202	5,128	0	1,187	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	521,600	196,663	37,634	43,436	44,079	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	28,100	12,017	0	2,781	0	192.00
193.00	19300	NONPAID WORKERS	1,948	1,334	0	309	0	193.00
194.00	07950	EMERALD POINT	6,657	0	20	0	29,204	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	558,305	210,014	37,654	46,526	73,283	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	22,932					11.00
13.00	01300	NURSING ADMINISTRATION	766	52,014				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	493	0	122,580			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	909	0	0	80,985		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,915	14,422	3,766	3,230		30.00
40.00	04000	SUBPROVIDER - IPF	2,633	13,026	774	2,725		40.00
43.00	04300	NURSERY	219	1,084	110	85		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,158	0	8,365	3,223		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	331	0	168	106		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	37		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,727	0	8,204	25,890		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	2,260	0	40,347	16,634		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	736	0	2,136	2,165		65.00
66.00	06600	PHYSICAL THERAPY	1,284	0	974	5,909		66.00
67.00	06700	OCCUPATIONAL THERAPY	206	0	0	976		67.00
68.00	06800	SPEECH PATHOLOGY	81	0	0	232		68.00
69.00	06900	ELECTROCARDIOLOGY	272	0	0	1,248		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	24,200	1,197		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,154	389		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	799	0	0	6,995		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	80	0	124	198		76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	192	0	15,085	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	4,749	23,482	4,598	6,977		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	2,758	2,769		95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,810	52,014	116,763	80,985	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	663	0	1,102	0		192.00
193.00	19300	NONPAID WORKERS	0	0	238	0		193.00
194.00	07950	EMERALD POINT	459	0	4,477	0		194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0		194.01
200.00		Cross Foot Adjustments						0 200.00
201.00		Negative Cost Centers	0	0	0	0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	22,932	52,014	122,580	80,985	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/30/2020 10:45 am

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
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	275,574	0	275,574	30.00
40.00	04000	SUBPROVIDER - IPF	151,304	0	151,304	40.00
43.00	04300	NURSERY	44,174	0	44,174	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	182,081	0	182,081	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,046	0	11,046	52.00
53.00	05300	ANESTHESIOLOGY	37	0	37	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,924	0	173,924	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	143,066	0	143,066	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	39,960	0	39,960	65.00
66.00	06600	PHYSICAL THERAPY	111,183	0	111,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,400	0	33,400	67.00
68.00	06800	SPEECH PATHOLOGY	12,169	0	12,169	68.00
69.00	06900	ELECTROCARDIOLOGY	6,513	0	6,513	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	30,410	0	30,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,612	0	6,612	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,835	0	55,835	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	8,091	0	8,091	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	435,981	0	435,981	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	113,667	0	113,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	68,094	0	68,094	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,903,121	0	1,903,121	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	121,727	0	121,727	192.00
193.00	19300	NONPAID WORKERS	12,392	0	12,392	193.00
194.00	07950	EMERALD POINT	118,309	0	118,309	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	194.01
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)	2,155,549	0	2,155,549	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	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	133,657				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		133,657			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	162	162	8,632,868		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,189	35,189	1,502,518	-6,712,678	5.00
6.00	00600	MAINTENANCE & REPAIRS	11,113	11,113	284,379	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,938	1,938	0	0	8.00
9.00	00900	HOUSEKEEPING	1,798	1,798	267,981	0	9.00
10.00	01000	DIETARY	3,383	3,383	158,945	0	10.00
11.00	01100	CAFETERIA	942	942	114,970	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,966	1,966	339,318	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,262	6,262	114,170	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,367	2,367	142	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,306	8,306	959,763	0	30.00
40.00	04000	SUBPROVIDER - IPF	4,486	4,486	649,682	0	40.00
43.00	04300	NURSERY	2,048	2,048	52,847	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,999	7,999	468,210	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	480	480	80,571	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,851	5,851	534,306	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,538	2,538	575,862	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,443	1,443	210,657	0	65.00
66.00	06600	PHYSICAL THERAPY	4,358	4,358	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,393	1,393	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	512	512	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	128	128	67,105	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	1,038	1,038	405,573	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	396	396	6,429	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	17,605	17,605	129,759	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,284	2,284	843,869	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,129	2,129	625,818	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,114	128,114	8,392,874	-6,712,678	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,989	4,989	140,096	0	192.00
193.00	19300	NONPAID WORKERS	554	554	34,182	0	193.00
194.00	07950	EMERALD POINT	0	0	65,716	0	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
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)	745,008	1,318,463	3,061,707	6,712,678	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.574029	9.864526	0.354657	0.303062	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,501	558,395	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000290	0.025206	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
			6.00	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
6.00	00600	MAINTENANCE & REPAIRS	87,193					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,938	80,743				8.00
9.00	00900	HOUSEKEEPING	1,798	0	83,457			9.00
10.00	01000	DIETARY	3,383	0	3,383	35,515		10.00
11.00	01100	CAFETERIA	942	0	942	0	216,911	11.00
13.00	01300	NURSING ADMINISTRATION	1,966	0	1,966	0	7,247	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,262	0	6,262	0	4,661	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,367	0	2,367	0	8,598	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,306	45,674	8,306	16,721	27,577	30.00
40.00	04000	SUBPROVIDER - IPF	4,486	29,738	4,486	4,641	24,908	40.00
43.00	04300	NURSERY	2,048	1,173	2,048	0	2,073	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,999	0	7,999	0	10,955	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	480	0	480	0	3,131	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,851	0	5,851	0	16,338	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,538	0	2,538	0	21,381	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,443	0	1,443	0	6,958	65.00
66.00	06600	PHYSICAL THERAPY	4,358	3,388	4,358	0	12,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,393	0	1,393	0	1,947	67.00
68.00	06800	SPEECH PATHOLOGY	512	0	512	0	765	68.00
69.00	06900	ELECTROCARDIOLOGY	128	0	128	0	2,576	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	1,038	0	1,038	0	7,562	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	396	0	396	0	756	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	17,605	727	17,605	0	1,816	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,284	0	2,284	0	44,903	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,129	0	2,129	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81,650	80,700	77,914	21,362	206,301	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,989	0	4,989	0	6,267	192.00
193.00	19300	NONPAID WORKERS	554	0	554	0	0	193.00
194.00	07950	EMERALD POINT	0	43	0	14,153	4,343	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	0	194.01
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)	1,983,289	202,614	783,218	676,006	317,789	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.745966	2.509369	9.384689	19.034380	1.465066	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	210,014	37,654	46,526	73,283	22,932	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.408611	0.466344	0.557485	2.063438	0.105721	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: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
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	99,461				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,008,393			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	59,002,522		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,577	30,978	2,352,398	0	30.00
40.00	04000	SUBPROVIDER - IPF	24,908	6,367	1,984,822	0	40.00
43.00	04300	NURSERY	2,073	909	61,859	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	68,812	2,347,457	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,385	76,957	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	26,818	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,491	18,876,121	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	331,905	12,114,821	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	17,574	1,576,803	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,010	4,303,504	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	710,653	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	168,846	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	909,186	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	199,078	871,861	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,395	283,050	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,094,570	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	1,019	144,102	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	124,093	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	44,903	37,828	5,081,755	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	22,692	2,016,939	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,461	960,536	59,002,522	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	9,067	0	0	192.00
193.00	19300	NONPAID WORKERS	0	1,961	0	0	193.00
194.00	07950	EMERALD POINT	0	36,829	0	0	194.00
194.01	07951	CONVENIENT CARE PRE-RHC	0	0	0	0	194.01
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)	847,480	559,717	1,976,212	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.520727	0.555058	0.033494	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,014	122,580	80,985	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.522959	0.121560	0.001373	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,257,436		3,257,436	0	3,257,436	30.00
40.00	04000	SUBPROVIDER - IPF	1,967,419		1,967,419	1,535	1,968,954	40.00
43.00	04300	NURSERY	320,525		320,525	0	320,525	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,526,224		1,526,224	0	1,526,224	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	105,185		105,185	0	105,185	52.00
53.00	05300	ANESTHESIOLOGY	898		898	0	898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,446,055		2,446,055	0	2,446,055	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,612,898		2,612,898	0	2,612,898	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	548,437	0	548,437	0	548,437	65.00
66.00	06600	PHYSICAL THERAPY	1,412,266	0	1,412,266	0	1,412,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	411,572	0	411,572	0	411,572	67.00
68.00	06800	SPEECH PATHOLOGY	148,995	0	148,995	0	148,995	68.00
69.00	06900	ELECTROCARDIOLOGY	173,743		173,743	0	173,743	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	398,875		398,875	0	398,875	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,255		88,255	0	88,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,704,891		1,704,891	0	1,704,891	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0		0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	39,876		39,876	0	39,876	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,617,863		5,617,863	0	5,617,863	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,345,576		2,345,576	0	2,345,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	555,309		555,309		555,309	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,348,010		1,348,010	0	1,348,010	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,030,308	0	27,030,308	1,535	27,031,843	200.00
201.00		Less Observation Beds	555,309		555,309		555,309	201.00
202.00		Total (see instructions)	26,474,999	0	26,474,999	1,535	26,476,534	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 10:45 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,194,399		2,194,399			30.00
40.00	04000	SUBPROVIDER - IPF	1,851,511		1,851,511			40.00
43.00	04300	NURSERY	57,704		57,704			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	147,031	2,200,426	2,347,457	0.650161	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,312	12,645	76,957	1.366802	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,040	15,778	26,818	0.033485	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	834,914	18,041,207	18,876,121	0.129585	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,457,995	10,656,826	12,114,821	0.215678	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	536,066	1,040,737	1,576,803	0.347816	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	428,222	3,875,282	4,303,504	0.328167	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	201,592	509,061	710,653	0.579146	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	56,316	112,530	168,846	0.882431	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	62,228	846,958	909,186	0.191097	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	283,545	588,316	871,861	0.457498	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,130	279,920	283,050	0.311800	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,278,671	3,815,899	5,094,570	0.334649	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0.000000	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	144,102	144,102	0.276721	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,135,346	3,135,346			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	463,200	4,618,555	5,081,755	0.461568	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	131,341	164,123	295,464	1.879447	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	169,794	1,847,145	2,016,939	0.668344	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,233,011	51,904,856	62,137,867			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,233,011	51,904,856	62,137,867			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 11/30/2020 10:45 am
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.650161			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.366802			52.00
53.00	05300	ANESTHESIOLOGY	0.033485			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129585			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.215678			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.347816			65.00
66.00	06600	PHYSICAL THERAPY	0.328167			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.579146			67.00
68.00	06800	SPEECH PATHOLOGY	0.882431			68.00
69.00	06900	ELECTROCARDIOLOGY	0.191097			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.457498			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311800			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334649			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.000000			75.01
76.97	07697	CARDIAC REHABILITATION	0.276721			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.461568			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.879447			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.668344			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/30/2020 10:45 am

			Title XVIII		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	275,574	2,896	272,678	1,602	170.21	30.00	
40.00	SUBPROVIDER - IPF	151,304	0	151,304	1,547	97.80	40.00	
43.00	NURSERY	44,174		44,174	61	724.16	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (lines 30 through 199)	471,052		468,156	3,210		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	796	135,487					30.00
40.00	SUBPROVIDER - IPF	1,076	105,233					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	1,872	240,720					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/30/2020 10:45 am

			Title XVIII		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	182,081	2,347,457	0.077565	32,131	2,492	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,046	76,957	0.143535	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37	26,818	0.001380	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,924	18,876,121	0.009214	742,412	6,841	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	143,066	12,114,821	0.011809	930,910	10,993	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	39,960	1,576,803	0.025342	359,132	9,101	65.00
66.00	06600	PHYSICAL THERAPY	111,183	4,303,504	0.025835	121,628	3,142	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,400	710,653	0.046999	9,236	434	67.00
68.00	06800	SPEECH PATHOLOGY	12,169	168,846	0.072072	20,706	1,492	68.00
69.00	06900	ELECTROCARDIOLOGY	6,513	909,186	0.007164	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	30,410	871,861	0.034879	93,710	3,269	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,612	283,050	0.023360	196	5	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,835	5,094,570	0.010960	330,980	3,628	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	8,091	144,102	0.056148	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	435,981	3,135,346	0.139054	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	113,667	5,081,755	0.022368	435,500	9,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	46,978	295,464	0.158997	41,851	6,654	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,410,953	56,017,314		3,118,392	57,792	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0137		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/30/2020 10:45 am	
					Title XVIII		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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	0	45.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	1,602	0.00	796	30.00		
40.00	04000	SUBPROVIDER - IPF	0	0	1,547	0.00	1,076	40.00		
43.00	04300	NURSERY	0	0	61	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00		
200.00		Total (lines 30 through 199)	0	0	3,210		1,872	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		
40.00	04000	SUBPROVIDER - IPF	0					40.00		
43.00	04300	NURSERY	0					43.00		
44.00	04400	SKILLED NURSING FACILITY	0					44.00		
45.00	04500	NURSING FACILITY	0					45.00		
200.00		Total (lines 30 through 199)	0					200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 10:45 am

			Title XVIII		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,347,457	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	76,957	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,818	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,876,121	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	12,114,821	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,576,803	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,303,504	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	710,653	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	168,846	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	909,186	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	871,861	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	283,050	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,094,570	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	144,102	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,135,346	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,081,755	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	295,464	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	56,017,314		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0137		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/30/2020 10:45 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		32,131	0	1,054,103	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		742,412	0	6,142,528	0	54.00
57.00	05700	CT SCAN	0.000000		0	0	0	0	57.00
58.00	05800	MRI	0.000000		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		930,910	0	1,432,499	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		359,132	0	802,997	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		121,628	0	5,482	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		9,236	0	122	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		20,706	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000		93,710	0	90,802	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		196	0	1,372	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		330,980	0	1,042,258	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.000000		0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	0	0	0	88.00
90.00	09000	CLINIC	0.000000		0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000		435,500	0	1,697,971	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000		41,851	0	92,517	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			3,118,392	0	12,362,651	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0137		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/30/2020 10:45 am	
				Title XVIII		Hospital		PPS	
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	0.650161	1,054,103	0	0	685,337	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.366802	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.033485	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129585	6,142,528	0	0	795,979	54.00	
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.215678	1,432,499	0	0	308,959	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0.347816	802,997	0	0	279,295	65.00	
66.00	06600	PHYSICAL THERAPY	0.328167	5,482	0	0	1,799	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.579146	122	0	0	71	67.00	
68.00	06800	SPEECH PATHOLOGY	0.882431	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.191097	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.457498	90,802	0	0	41,542	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311800	1,372	0	0	428	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334649	1,042,258	0	2,451	348,791	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.000000	0	0	0	0	75.01	
76.97	07697	CARDIAC REHABILITATION	0.276721	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.461568	1,697,971	0	97	783,729	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.879447	92,517	0	0	173,881	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.668344	0	0	0	0	95.00	
200.00		Subtotal (see instructions)		12,362,651	0	2,548	3,419,811	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00	
202.00		Net Charges (line 200 - line 201)		12,362,651	0	2,548	3,419,811	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0137		Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 11/30/2020 10:45 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
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 PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	820		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	45		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	865		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	865		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 11/30/2020 10:45 am		
				Title XVIII	Subprovider - IPF	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	182,081	2,347,457	0.077565	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,046	76,957	0.143535	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37	26,818	0.001380	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,924	18,876,121	0.009214	34,508	318	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	143,066	12,114,821	0.011809	159,108	1,879	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	39,960	1,576,803	0.025342	8,616	218	65.00
66.00	06600	PHYSICAL THERAPY	111,183	4,303,504	0.025835	40,852	1,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,400	710,653	0.046999	5,686	267	67.00
68.00	06800	SPEECH PATHOLOGY	12,169	168,846	0.072072	2,350	169	68.00
69.00	06900	ELECTROCARDIOLOGY	6,513	909,186	0.007164	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	30,410	871,861	0.034879	403	14	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,612	283,050	0.023360	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,835	5,094,570	0.010960	159,455	1,748	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	8,091	144,102	0.056148	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	435,981	3,135,346	0.139054	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	113,667	5,081,755	0.022368	26,850	601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	295,464	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,363,975	56,017,314		437,828	6,269	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0137 Component CCN: 14-S137		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/30/2020 10:45 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0	60.01
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 PAT		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
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS		0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
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: 14-0137 Component CCN: 14-S137		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/30/2020 10:45 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	2,347,457	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	76,957	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	26,818	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	18,876,121	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	12,114,821	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY		0	0	0	1,576,803	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	4,303,504	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	710,653	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	168,846	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	909,186	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		0	0	0	871,861	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	283,050	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	5,094,570	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS		0	0	0	0	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	144,102	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	3,135,346	0.000000	88.00
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	5,081,755	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0	0	0	295,464	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	56,017,314		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0137
Component CCN: 14-S137

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 10:45 am

				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	34,508	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	159,108	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	8,616	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	40,852	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,686	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,350	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	403	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	159,455	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.000000	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	26,850	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		437,828	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0137

Period:

Worksheet D

Component CCN: 14-U137

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
11/30/2020 10:45 am

			Title XVIII		Swing Beds - SNF		PPS		
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	0.650161	0	0	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.366802	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.033485	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129585	0	0	0	0	54.00	
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.215678	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0.347816	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.328167	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.579146	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.882431	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.191097	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.457498	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311800	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334649	0	0	0	0	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.000000	0	0	0	0	75.01	
76.97	07697	CARDIAC REHABILITATION	0.276721	0	0	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.461568	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.879447	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.668344		0			95.00	
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: 14-0137

Period:

Worksheet D

Component CCN: 14-U137

From 07/01/2019

Part V

To 06/30/2020

Date/Time Prepared:

11/30/2020 10:45 am

Title XVIII

Swing Beds - SNF

PPS

Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
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 PAT	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/30/2020 10:45 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,545	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,602	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,326	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		365	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)		364	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		107	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)		107	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		796	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)		231	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)		326	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,257,436	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)		17,117	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		17,117	25.00
26.00	Total swing-bed cost (see instructions)		34,234	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,223,202	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)		3,223,202	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,011.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,601,544	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,601,544	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description		Title XVIII		Hospital		PPS
		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)	0	0	0.00	0	0
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)					939,684
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,541,228
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					135,487
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					57,792
52.00	Total Program excludable cost (sum of lines 50 and 51)					193,279
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,347,949
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					276
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,011.99
89.00	Observation bed cost (line 87 x line 88) (see instructions)					555,309

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description		Title XVIII		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	275,574	3,257,436	0.084598	555,309	46,978
91.00	Nursing School cost	0	3,257,436	0.000000	555,309	0
92.00	Allied health cost	0	3,257,436	0.000000	555,309	0
93.00	All other Medical Education	0	3,257,436	0.000000	555,309	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/30/2020 10:45 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,547	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,547	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,076	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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		159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,968,954	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,968,954	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)		1,968,954	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)		1,272.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,369,490	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,369,490	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/30/2020 10:45 am
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
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)					126,496
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,495,986
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					105,233
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,269
52.00 Total Program excludable cost (sum of lines 50 and 51)					111,502
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,384,484
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0137 Component CCN: 14-S137		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/30/2020 10:45 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	151,304	1,968,954	0.076845		0		0	90.00
91.00	Nursing School cost	0	1,968,954	0.000000		0		0	91.00
92.00	Allied health cost	0	1,968,954	0.000000		0		0	92.00
93.00	All other Medical Education	0	1,968,954	0.000000		0		0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/30/2020 10:45 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		859,469	30.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.650161	32,131	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.366802	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033485	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129585	742,412	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.215678	930,910	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.347816	359,132	65.00
66.00	06600	PHYSICAL THERAPY	0.328167	121,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.579146	9,236	67.00
68.00	06800	SPEECH PATHOLOGY	0.882431	20,706	68.00
69.00	06900	ELECTROCARDIOLOGY	0.191097	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.457498	93,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311800	196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334649	330,980	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.276721	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.461568	435,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.879447	41,851	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,118,392	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)		3,118,392	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/30/2020 10:45 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
40.00	04000 SUBPROVIDER - IPF		1,104,350		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.650161	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.366802	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.033485	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.129585	34,508	4,472	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.215678	159,108	34,316	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.347816	8,616	2,997	65.00
66.00	06600 PHYSICAL THERAPY	0.328167	40,852	13,406	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.579146	5,686	3,293	67.00
68.00	06800 SPEECH PATHOLOGY	0.882431	2,350	2,074	68.00
69.00	06900 ELECTROCARDIOLOGY	0.191097	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.457498	403	184	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.311800	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.334649	159,455	53,361	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0.000000	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.276721	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.461568	26,850	12,393	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.879447	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		437,828	126,496	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)		437,828		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0137 Component CCN: 14-U137	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/30/2020 10:45 am	
Cost Center Description			Title XVIII	Swing Beds - SNF	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.650161	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.366802	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.033485	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129585	57,028	7,390	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.215678	149,820	32,313	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.347816	94,611	32,907	65.00
66.00	06600	PHYSICAL THERAPY	0.328167	139,891	45,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.579146	111,668	64,672	67.00
68.00	06800	SPEECH PATHOLOGY	0.882431	14,375	12,685	68.00
69.00	06900	ELECTROCARDIOLOGY	0.191097	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.457498	30,890	14,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.311800	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.334649	123,285	41,257	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.000000	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.276721	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.461568	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.879447	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		721,568	251,264	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)		721,568		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/30/2020 10:45 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		444,668	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,055,825	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		25.67	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		11.92	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.01	31.00
32.00	Sum of lines 30 and 31		30.93	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		45,015	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/30/2020 10:45 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000028563	0.000026470	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	236,295	221,042	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	59,559	165,480	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	225,039		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,770,547		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
		Amount		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		1,770,547	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		120,277	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,890,824	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,890,824	61.00
62.00	Deductibles billed to program beneficiaries		191,884	62.00
63.00	Coinsurance billed to program beneficiaries		4,510	63.00
64.00	Allowable bad debts (see instructions)		12,958	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		8,423	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,688	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,702,853	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		6,473	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/30/2020 10:45 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2019	138,374	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2020	300,089	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,147,789	71.00
71.01	Sequestration adjustment (see instructions)		35,868	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		2,039,811	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		72,110	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		111,146	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2020 10:45 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	444,668	0	444,668		444,668
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,055,825	0		1,055,825	1,055,825
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	
11.00	Disproportionate share adjustment (see instructions)	34.00	45,015	0	13,340	31,675	45,015
11.01	Uncompensated care payments	36.00	225,039	0	59,559	165,480	225,039
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	1,770,547	0	517,567	1,252,980	1,770,547
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,770,547	0	517,567	1,252,980	1,770,547
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	120,277	0	35,928	84,349	120,277

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2020 10:45 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	553,495	1,337,329	1,890,824
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	120,277	0	35,928	84,349	120,277
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	120,277	0	35,928	84,349	120,277
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.250000	0.224394	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			138,374		138,374
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				300,089	300,089
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2020 10:45 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	444,668	444,668		444,668	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,055,825		1,055,825	1,055,825	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	45,015	13,340	31,675	45,015	11.00
11.01	Uncompensated care payments	36.00	225,039	53,181	176,736	229,917	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,770,547	511,189	1,259,358	1,770,547	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,770,547	511,189	1,259,358	1,770,547	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	120,277	35,928	84,349	120,277	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			547,117	1,343,707	1,890,824	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2020 10:45 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	120,277	35,928	84,349	120,277	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	120,277	35,928	84,349	120,277	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	138,374	138,374		138,374	28.00
29.00	Low volume adjustment on or after October 1	70.97	300,089		300,089	300,089	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	6,473	6,473	0	6,473	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/30/2020 10:45 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		865	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,419,811	2.00
3.00	OPPS payments		1,847,731	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)		865	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,548	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)		2,548	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)		2,548	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,683	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)		865	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)		1,847,731	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		384,448	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)		1,464,148	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)		1,464,148	30.00
31.00	Primary payer payments		993	31.00
32.00	Subtotal (line 30 minus line 31)		1,463,155	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)		7,293	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		4,740	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,379	36.00
37.00	Subtotal (see instructions)		1,467,895	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-174	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,468,069	40.00
40.01	Sequestration adjustment (see instructions)		24,517	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,437,393	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		6,159	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/30/2020 10:45 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,039,811		1,437,393	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)		2,039,811		1,437,393	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		72,110		6,159	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,111,921		1,443,552	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: 14-0137 Component CCN: 14-S137		Period: From 07/01/2019 To 06/30/2020		Worksheet E-1 Part I Date/Time Prepared: 11/30/2020 10:45 am	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		906,812		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)		906,812		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		3,053		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		909,865		0	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: 14-0137
 Component CCN: 14-U137

 Period:
 From 07/01/2019
 To 06/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/30/2020 10:45 am

		Title XVIII		Swing Beds - SNF		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		286,898		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)		286,898		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		966		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		287,864		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: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/30/2020 10:45 am

Title XVIII

Hospital

PPS

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: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2	
		Component CCN: 14-U137		Date/Time Prepared: 11/30/2020 10:45 am	
		Title XVIII	Swing Beds - SNF	PPS	
			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)		314,797	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		557	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)		314,797	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		314,797	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)		314,797	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		22,044	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		292,753	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)		292,753	0	19.00
19.01	Sequestration adjustment (see instructions)		4,889	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		286,898	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		966	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0137 Component CCN: 14-S137	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part II Date/Time Prepared: 11/30/2020 10:45 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		978,630	1.00
2.00	Net IPF PPS Outlier Payments		14,668	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		4.226776	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		993,298	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		993,298	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		993,298	18.00
19.00	Deductibles		60,588	19.00
20.00	Subtotal (line 18 minus line 19)		932,710	20.00
21.00	Coinsurance		7,392	21.00
22.00	Subtotal (line 20 minus line 21)		925,318	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		925,318	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		925,318	31.00
31.01	Sequestration adjustment (see instructions)		15,453	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		906,812	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		3,053	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		14,668	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:

11/30/2020 10:45 am

		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	8,154,648	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,468,580	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,987,474	0	0	0	6.00
7.00	Inventory	394,109	0	0	0	7.00
8.00	Prepaid expenses	662,148	0	0	0	8.00
9.00	Other current assets	684,670	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)	12,376,681	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,540,441	0	0	0	12.00
13.00	Land improvements	406,675	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	7,514,794	0	0	0	15.00
16.00	Accumulated depreciation	-3,348,335	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,261,624	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,781,903	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,157,102	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	867,136	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	867,136	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,400,919	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,560,223	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,241,809	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	833,037	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	3,647,408	0	0	0	43.00
44.00	Other current liabilities	8,608,496	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,890,973	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	31,864,466	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,047,880	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	33,912,346	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,803,319	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-24,402,400	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-24,402,400	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,400,919	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
11/30/2020 10:45 am

		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		-12,999,567		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-11,030,537				2.00
3.00	Total (sum of line 1 and line 2)		-24,030,104		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-24,030,104		0		11.00
12.00	NET TRANSFERS	372,295		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)		372,295		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-24,402,399		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	NET TRANSFERS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2020 10:45 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,726,573		1,726,573	1.00
2.00	SUBPROVIDER - IPF	1,851,511		1,851,511	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	482,384		482,384	5.00
6.00	Swing bed - NF	51,589		51,589	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,112,057		4,112,057	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)	4,112,057		4,112,057	17.00
18.00	Ancillary services	5,385,924	42,825,226	48,211,150	18.00
19.00	Outpatient services	552,831	4,878,303	5,431,134	19.00
20.00	RURAL HEALTH CLINIC	0	3,172,374	3,172,374	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	169,794	1,848,830	2,018,624	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL SERVICES	129,874	738,126	868,000	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,350,480	53,462,859	63,813,339	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,520,118		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)		33,520,118		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0137

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
11/30/2020 10:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,813,339	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,629,146	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,184,193	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,520,118	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,335,925	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,562	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	50,371	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	91	16.00
17.00	Revenue from sale of drugs to other than patients	179	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	893	21.00
22.00	Rental of hospital space	212,109	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	290,418	24.00
24.01	AUX REVENUE	414,735	24.01
24.02	INVESTMENT INCOME	7,099	24.02
24.03	COVID RELIEF FUNDS	0	24.03
24.50	COVID-19 PHE Funding	2,602,765	24.50
25.00	Total other income (sum of lines 6-24)	3,580,222	25.00
26.00	Total (line 5 plus line 25)	-10,755,703	26.00
27.00	PENSION MARK TO MARKET	274,834	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	274,834	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-11,030,537	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/30/2020 10:45 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		120,277	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)		3.92	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)		120,277	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: 14-0137

Period:

Worksheet M-1

Component CCN: 14-8519

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 10:45 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	0	1,288,858	1,288,858	-11,461	1,277,397	1.00
2.00 Physician Assistant	0	0	0	0	0	2.00
3.00 Nurse Practitioner	92,867	768,534	861,401	-5,020	856,381	3.00
4.00 Visiting Nurse	0	0	0	0	0	4.00
5.00 Other Nurse	0	687,191	687,191	0	687,191	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	0	0	0	0	0	9.00
10.00 Subtotal (sum of lines 1 through 9)	92,867	2,744,583	2,837,450	-16,481	2,820,969	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	101,765	101,765	0	101,765	15.00
16.00 Transportation (Health Care Staff)	0	43,668	43,668	0	43,668	16.00
17.00 Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00 Professional Liability Insurance	0	0	0	0	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	145,433	145,433	0	145,433	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	92,867	2,890,016	2,982,883	-16,481	2,966,402	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00 Pharmacy	0	12,158	12,158	0	12,158	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	16,481	16,481	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	12,158	12,158	16,481	28,639	28.00
FACILITY OVERHEAD						
29.00 Facility Costs	0	7,828	7,828	0	7,828	29.00
30.00 Administrative Costs	36,892	202,735	239,627	0	239,627	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	36,892	210,563	247,455	0	247,455	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	129,759	3,112,737	3,242,496	0	3,242,496	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0137

Period:

Worksheet M-1

Component CCN: 14-8519

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 10:45 am

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,277,397		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	856,381		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	687,191		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,820,969		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	101,765		15.00
16.00	Transportation (Health Care Staff)	0	43,668		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	145,433		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,966,402		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	12,158		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	16,481		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	28,639		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	7,828		29.00
30.00	Administrative Costs	260,568	500,195		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	260,568	508,023		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	260,568	3,503,064		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0137

Period:

Worksheet M-2

Component CCN: 14-8519

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 10:45 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.92	3,927	4,200	12,264		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.52	5,879	2,100	9,492		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.44	9,806		21,756	21,756	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)	7.44	9,806			21,756	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,966,402	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					28,639	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,995,041	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990438	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					508,023	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,114,799	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,622,822	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,622,822	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,597,743	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,564,145	20.00

Health Financial Systems		GREENVILLE REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0137	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-8519		Date/Time Prepared: 11/30/2020 10:45 am	
		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)			5,564,145	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			95,960	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,468,185	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,756	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)			21,756	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			251.34	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		251.34	251.34	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,903	1,508	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		478,300	379,021	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	857,321	16.00
16.01	Total program charges (see instructions)(from contractor's records)			686,440	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			900	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			1,124	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.)			627,820	16.04
16.05	Total program cost (see instructions)		0	628,944	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			71,422	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			122,824	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			628,944	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			40,940	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			669,884	22.00
23.00	Allowable bad debts (see instructions)			31,450	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			20,443	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			23,035	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)			690,327	26.00
26.01	Sequestration adjustment (see instructions)			11,528	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			546,807	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)			131,992	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: 14-0137 Component CCN: 14-8519	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/30/2020 10:45 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,820,969	2,820,969	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000581	0.001866	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,639	5,264	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		30,666	13,591	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		32,305	18,855	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,966,402	2,966,402	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,597,743	2,597,743	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010890	0.006356	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		28,289	16,511	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		60,594	35,366	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		185	594	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		327.54	59.54	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		85	220	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		27,841	13,099	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)			95,960	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)			40,940	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0137 Component CCN: 14-8519	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/30/2020 10:45 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		546,807	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)		546,807	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		131,992	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		678,799	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00