

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/30/2020 3:35 pm
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/30/2020	Time: 3:35 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RED BUD REGIONAL HOSPITAL (14-1348) for the cost reporting period beginning 07/01/2019 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) VERONICA MARIN

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	338,125	538,618	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	449,093	103		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		426,446		0	10.00
200.00	Total	0	787,218	965,167	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 3:35 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: ST. CLEMENT BLVD			PO Box:				1.00		
2.00	City: RED BUD			State: IL		Zip Code: 62278-		County: RANDOLPH		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	N	O	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		RED BUD HOSPITAL	14Z348	99914		08/10/2005	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020		
21.00	Type of Control (see instructions)						4			
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
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			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 3:35 pm	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr	
							1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0	35.00
							Beginning:	Ending:	
							1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							0	37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
							Y/N	Y/N	
							1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)							N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)							N	40.00
							V	XVIII	XIX
							1.00	2.00	3.00
<u>Prospective Payment System (PPS)-Capital</u>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)							N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.							N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.							N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N	48.00
<u>Teaching Hospitals</u>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.							N	56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							N	58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							N	59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.							N	60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 3:35 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	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.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 3:35 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
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		0115.00
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:	98,284	47,969	0118.01
		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	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/30/2020 3:35 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: QUORUM HEALTH		Contractor's Name: WPS		Contractor's Number: 52280				141.00
142.00	Street: 1573 MALLORY LANE SUITE 100		PO Box:						142.00
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027				143.00
									1.00
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
									1.00
									2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
									1.00
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
									1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part II Date/Time Prepared: 11/30/2020 3:35 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	10/05/2020	Y	10/05/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2019	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.	LUCIE	GREEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-227-3747	LUCIE_GREEN@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/30/2020 3:35 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	47,544.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	47,544.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	47,544.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,450	18	1,981			1.00
2.00	HMO and other (see instructions)	200	57				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2,713	0	3,164			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		21	290			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,163	39	5,435			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)	4,163	39	5,435	0.00	127.23	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	6,213	0	15,675	0.00	34.47	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	161.70	27.00
28.00	Observation Bed Days		0	557			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	411	5	579	1.00
2.00 HMO and other (see instructions)			44	16		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	411	5	579	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		RED BUD REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1348 Component CCN: 14-8514		Period: From 07/01/2019 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 11/30/2020 3:35 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	325 SPRING STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	RED BUD IL 62278		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		05:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	RANDOLPH		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	05:00	08:00	05:00	08:00

Health Financial Systems		RED BUD REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1348	Period: From 07/01/2019	Worksheet S-8
			Component CCN: 14-8514	To 06/30/2020	Date/Time Prepared: 11/30/2020 3:35 pm
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	05:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/30/2020 3:35 pm
			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.178703	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,002,709	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		777,749	5.00
6.00	Medicaid charges		13,573,898	6.00
7.00	Medicaid cost (line 1 times line 6)		2,425,696	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)		645,238	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)		645,238	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,081,617	0	1,081,617
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	193,288	0	193,288
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	193,288	0	193,288
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,351,263	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		416,973	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		641,497	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,709,766	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		530,064	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		723,352	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,368,590	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1348

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

Worksheet A

Date/Time Prepared:
11/30/2020 3:35 pm

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		399,346	399,346	101,130	500,476	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		806,064	806,064	463,819	1,269,883	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	138,952	132,788	271,740	1,403,088	1,674,828	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,085,208	6,955,349	8,040,557	-1,649,520	6,391,037	5.00
7.00	00700	OPERATION OF PLANT	235,779	1,013,623	1,249,402	-48,128	1,201,274	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,866	76,866	0	76,866	8.00
9.00	00900	HOUSEKEEPING	181,437	45,013	226,450	-13,335	213,115	9.00
10.00	01000	DIETARY	0	723,223	723,223	-411,223	312,000	10.00
11.00	01100	CAFETERIA	0	0	0	410,381	410,381	11.00
13.00	01300	NURSING ADMINISTRATION	552,756	218,928	771,684	-66,536	705,148	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,336	159,382	187,718	-115,671	72,047	14.00
15.00	01500	PHARMACY	354,347	412,586	766,933	-366,257	400,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	87,844	49,387	137,231	-2,223	135,008	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,942,430	340,720	2,283,150	29,485	2,312,635	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	317,532	132,648	450,180	-10,801	439,379	50.00
53.00	05300	ANESTHESIOLOGY	0	51,766	51,766	0	51,766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,051	717,135	1,275,186	-142,102	1,133,084	54.00
60.00	06000	LABORATORY	575,540	545,732	1,121,272	-22,277	1,098,995	60.00
65.00	06500	RESPIRATORY THERAPY	220,506	57,621	278,127	-26,866	251,261	65.00
66.00	06600	PHYSICAL THERAPY	490,304	57,673	547,977	-1,079	546,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,267	12,197	162,464	0	162,464	67.00
68.00	06800	SPEECH PATHOLOGY	55,920	4,683	60,603	0	60,603	68.00
69.00	06900	ELECTROCARDIOLOGY	18,858	6,141	24,999	4,494	29,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	70,530	70,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,387	52,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	391,922	391,922	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	4,444	15,121	19,565	0	19,565	76.01
76.02	03020	PSYCH SERVICES	10,954	393,044	403,998	-1,073	402,925	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,403,247	965,319	4,368,566	-218,455	4,150,111	88.00
91.00	09100	EMERGENCY	2,194,080	815,465	3,009,545	-133,285	2,876,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,606,792	15,107,820	27,714,612	-301,595	27,413,017	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-14,230	-14,230	38,532	24,302	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	124,186	124,186	194.01
194.02	07952	SENIOR CIRCLE	29,880	7,883	37,763	-2,294	35,469	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	145,898	15,830	161,728	-44,867	116,861	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	186,038	186,038	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	12,782,570	15,117,303	27,899,873	0	27,899,873	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1348

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

Worksheet A

Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	111,581	612,057	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-104,110	1,165,773	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-316	1,674,512	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,771,486	4,619,551	5.00
7.00	00700	OPERATION OF PLANT	-13,587	1,187,687	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,866	8.00
9.00	00900	HOUSEKEEPING	0	213,115	9.00
10.00	01000	DIETARY	635,544	947,544	10.00
11.00	01100	CAFETERIA	-6,488	403,893	11.00
13.00	01300	NURSING ADMINISTRATION	0	705,148	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	72,047	14.00
15.00	01500	PHARMACY	0	400,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20	134,988	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-72,696	2,239,939	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	439,379	50.00
53.00	05300	ANESTHESIOLOGY	-45,000	6,766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-29,890	1,103,194	54.00
60.00	06000	LABORATORY	-56,226	1,042,769	60.00
65.00	06500	RESPIRATORY THERAPY	0	251,261	65.00
66.00	06600	PHYSICAL THERAPY	0	546,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	162,464	67.00
68.00	06800	SPEECH PATHOLOGY	0	60,603	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	70,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-952	390,970	73.00
76.00	03610	BLANK	0	0	76.00
76.01	03550	SLEEP LAB	0	19,565	76.01
76.02	03020	PSYCH SERVICES	0	402,925	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-625,903	3,524,208	88.00
91.00	09100	EMERGENCY	-1,058,628	1,817,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,038,177	24,374,840	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,302	192.00
194.00	07950	HOME HEALTH	0	0	194.00
194.01	07951	MARKETING	0	124,186	194.01
194.02	07952	SENIOR CIRCLE	0	35,469	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	116,861	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	186,038	194.05
194.06	07956	CLINIC CORPORATION	0	0	194.06
194.07	07957	VACANT SPACE	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,038,177	24,861,696	200.00

RECLASSIFICATIONS

Provider CCN: 14-1348

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

Worksheet A-6

Date/Time Prepared:
11/30/2020 3:35 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,485,277	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	79,041	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	1,564,318	
B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	12,081	1.00
	0		0	12,081	
C - RENTAL EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	457,236	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	38,532	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	495,768	
D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	47,243	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,583	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53,887	3.00
	0		0	107,713	
E - MARKETING COSTS					
1.00	MARKETING	194.01	66,710	57,476	1.00
	0		66,710	57,476	
F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	58,449	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	52,387	2.00
	0		0	110,836	
G - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	352,804	1.00
	0		0	352,804	
H - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	0	410,381	1.00
	0		0	410,381	
I - ALLOCATE NURSING HOME COSTS					
1.00	FREE STANDING NURSING HOME	194.05	179,756	6,282	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		179,756	6,282	
L - RECLASS MALPRACTICE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	253,072	1.00
	0		0	253,072	
M - HOUSE SUPERVISORS					
1.00	ADULTS & PEDIATRICS	30.00	51,467	0	1.00
	TOTALS		51,467	0	
N - RECLASS OF SPECIALTY CLINIC COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	39,118	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	4,494	0	2.00
	TOTALS		43,612	0	
500.00	Grand Total: Increases		341,545	3,370,731	500.00

RECLASSIFICATIONS

Provider CCN: 14-1348

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

Worksheet A-6

Date/Time Prepared:
11/30/2020 3:35 pm

Decreases						wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	58,600	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,372,172	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,716	0		3.00
4.00	EMERGENCY	91.00	0	131,830	0		4.00
	0		0	1,564,318			
B - OXYGEN COSTS							
1.00	RESPIRATORY THERAPY	65.00	0	12,081	0		1.00
	0		0	12,081			
C - RENTAL EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	206,810	10		1.00
2.00	OPERATION OF PLANT	7.00	0	4,725	0		2.00
3.00	RED BUD SPECIALTY CLINIC	194.03	0	1,255	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	1,069	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,835	0		5.00
6.00	PHARMACY	15.00	0	13,453	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,223	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	20,266	0		8.00
9.00	OPERATING ROOM	50.00	0	10,801	0		9.00
10.00	DIETARY	10.00	0	842	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	142,102	0		11.00
12.00	LABORATORY	60.00	0	22,277	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	14,785	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,079	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	44,424	0		15.00
16.00	EMERGENCY	91.00	0	1,455	0		16.00
17.00	SENIOR CIRCLE	194.02	0	2,294	0		17.00
18.00	PSYCH SERVICES	76.02	0	1,073	0		18.00
	0		0	495,768			
D - OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	107,713	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	107,713			
E - MARKETING COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	66,710	57,476	0		1.00
	0		66,710	57,476			
F - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	110,836	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	110,836			
G - RECLASS COST OF DRUGS/IV SOLUTIONS							
1.00	PHARMACY	15.00	0	352,804	0		1.00
	0		0	352,804			
H - CAFETERIA COSTS							
1.00	DIETARY	10.00	0	410,381	0		1.00
	0		0	410,381			
I - ALLOCATE NURSING HOME COSTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	23,589	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	88,545	3,166	0		2.00
3.00	OPERATION OF PLANT	7.00	40,287	3,116	0		3.00
4.00	NURSING ADMINISTRATION	13.00	14,000	0	0		4.00
5.00	HOUSEKEEPING	9.00	13,335	0	0		5.00
	0		179,756	6,282			
L - RECLASS MALPRACTICE EXPENSE							
1.00	RURAL HEALTH CLINIC	88.00	0	253,072	0		1.00
	0		0	253,072			
M - HOUSE SUPERVISORS							
1.00	NURSING ADMINISTRATION	13.00	51,467	0	0		1.00
	TOTALS		51,467	0			
N - RECLASS OF SPECIALTY CLINIC COSTS							
1.00	RED BUD SPECIALTY CLINIC	194.03	43,612	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		43,612	0			
500.00	Grand Total: Decreases		341,545	3,370,731			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	311,428	0	0	0	0	2.00	
3.00	Buildings and Fixtures	4,727,104	18,694	0	18,694	15,487	3.00	
4.00	Building Improvements	4,913,047	125,627	0	125,627	11,467	4.00	
5.00	Fixed Equipment	2,579,177	0	0	0	0	5.00	
6.00	Movable Equipment	12,548,733	274,402	0	274,402	112,259	6.00	
7.00	HIT designated Assets	3,060,668	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	28,140,157	418,723	0	418,723	139,213	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	28,140,157	418,723	0	418,723	139,213	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	311,428	0				2.00	
3.00	Buildings and Fixtures	4,730,311	0				3.00	
4.00	Building Improvements	5,027,207	0				4.00	
5.00	Fixed Equipment	2,579,177	0				5.00	
6.00	Movable Equipment	12,710,876	0				6.00	
7.00	HIT designated Assets	3,060,668	0				7.00	
8.00	Subtotal (sum of lines 1-7)	28,419,667	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	28,419,667	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	399,346	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	806,064	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,205,410	0	0	0	0	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	399,346				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	806,064				2.00
3.00	Total (sum of lines 1-2)	0	1,205,410				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,648,123	0	12,648,123	0.445048	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,771,544	0	15,771,544	0.554952	0	2.00
3.00	Total (sum of lines 1-2)	28,419,667	0	28,419,667	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	510,927	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	701,954	457,236	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,212,881	457,236	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	101,130	0	0	612,057	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,583	0	1,165,773	2.00
3.00	Total (sum of lines 1-2)	0	101,130	6,583	0	1,777,830	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1348

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

Worksheet A-8

Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-12,667	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-888	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-825,179			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-56	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-216,458			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-6,488	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-952	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	32,537	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-113,814	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1348

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

Worksheet A-8

Date/Time Prepared:
11/30/2020 3:35 pm

			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	
33.00 PATIENT TELEPHONE BENEFITS EXPENSE	A	-316	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
36.00 COST OF ER PROFESSIONAL BILLING	A	-62,699	EMERGENCY	91.00	0	36.00
38.00 NON RHC COSTS	A	-581,359	RURAL HEALTH CLINIC	88.00	0	38.00
38.03 TELEPHONE SERVICES	A	-1,875	ADMINISTRATIVE & GENERAL	5.00	0	38.03
38.04 NH RADIOLOGY COSTS	A	-2,547	RADIOLOGY-DIAGNOSTIC	54.00	9	38.04
39.00 ADVERTISING	A	-106,156	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01 PROFESSIONAL FEE BENEFITS	A	-7,299	ADULTS & PEDIATRICS	30.00	0	39.01
39.02 NH LAB COSTS	A	-8,237	LABORATORY	60.00	0	39.02
41.00 PROFESSIONAL FEE BENEFITS	A	-51,073	EMERGENCY	91.00	0	41.00
42.00 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-9,250	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00 LOBBYING EXPENSE	A	-8,839	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.01 CRNA COSTS	A	-287,527	EMERGENCY	91.00	0	45.01
45.02 CRNA BENEFITS	A	-17,823	EMERGENCY	91.00	0	45.02
45.03 ILLINOIS PROVIDER TAX	A	-1,255,002	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04 ADD BACK NH CREDIT FOR DIETARY	A	635,544	DIETARY	10.00	0	45.04
45.06 MISCELLANEOUS INCOME	B	-70,653	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07 CHARITABLE CONTRIBUTIONS	A	-950	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08 RHC MISC INCOME	B	-44,544	RURAL HEALTH CLINIC	88.00	0	45.08
45.09 PATIENT TV - CABLE EXPENSE	A	-13,587	OPERATION OF PLANT	7.00	0	45.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,038,177				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1348

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2020 3:35 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	54,835	0 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	193,464	0 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	79,044	0 3.00
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	10,592	0 4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	469,342	0 4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	146,253	313,920 4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	856,068 4.03
4.04		0.00			0	0 4.04
4.05		0.00			0	0 4.05
4.06		0.00			0	0 4.06
4.07		0.00			0	0 4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				953,530	1,169,988 5.00

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

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

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

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

6.00	B	QUORUM HEALTH C	100.00	QUORUM HEALTH C	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1348

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2020 3:35 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	54,835	0		1.00
2.00	193,464	0		2.00
3.00	79,044	9		3.00
4.00	10,592	9		4.00
4.01	469,342	0		4.01
4.02	-167,667	0		4.02
4.03	-856,068	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	-216,458			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

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

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

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

6.00	HOSPITAL CORP		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1348

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

Worksheet A-8-2

Date/Time Prepared:
11/30/2020 3:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	65,397	65,397	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	1,430,662	639,506	791,156	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	45,000	45,000	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	27,287	27,287	0	0	0	6.00
7.00	60.00	LABORATORY	47,989	47,989	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,616,335	825,179	791,156			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	65,397		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	639,506		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	45,000		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	27,287		6.00
7.00	60.00	LABORATORY	0	0	0	47,989		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	825,179		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	612,057	612,057			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,165,773		1,165,773		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,674,512	11,293	22,351	1,708,156	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,619,551	91,358	180,821	125,403	5.00
7.00	00700	OPERATION OF PLANT	1,187,687	139,707	276,515	26,362	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,866	1,350	2,672	0	8.00
9.00	00900	HOUSEKEEPING	213,115	9,747	19,292	22,668	9.00
10.00	01000	DIETARY	947,544	26,048	51,555	0	10.00
11.00	01100	CAFETERIA	403,893	15,347	30,376	0	11.00
13.00	01300	NURSING ADMINISTRATION	705,148	7,101	14,055	65,710	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,047	5,546	10,977	3,821	14.00
15.00	01500	PHARMACY	400,676	7,365	14,578	47,783	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	134,988	15,528	30,734	11,846	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,239,939	65,433	124,368	268,875	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	439,379	34,890	69,057	42,819	50.00
53.00	05300	ANESTHESIOLOGY	6,766	748	1,481	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,103,194	24,263	48,022	75,253	54.00
60.00	06000	LABORATORY	1,042,769	14,095	27,898	77,611	60.00
65.00	06500	RESPIRATORY THERAPY	251,261	1,761	3,485	29,735	65.00
66.00	06600	PHYSICAL THERAPY	546,898	18,722	39,088	66,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,464	856	4,801	20,263	67.00
68.00	06800	SPEECH PATHOLOGY	60,603	0	0	7,541	68.00
69.00	06900	ELECTROCARDIOLOGY	29,493	1,223	2,420	3,149	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	70,530	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,387	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,970	0	0	5,275	73.00
76.00	03610	BLANK	0	0	0	0	76.00
76.01	03550	SLEEP LAB	19,565	4,827	9,554	599	76.01
76.02	03020	PSYCH SERVICES	402,925	10,686	21,151	1,477	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,524,208	43,048	85,203	458,922	88.00
91.00	09100	EMERGENCY	1,817,632	14,770	29,233	295,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,374,840	565,712	1,119,687	1,657,098	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,302	18,233	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING	124,186	1,585	3,136	8,996	194.01
194.02	07952	SENIOR CIRCLE	35,469	3,169	6,273	4,029	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	116,861	18,531	36,677	13,793	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	186,038	0	0	24,240	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	4,827	0	0	194.07
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	24,861,696	612,057	1,165,773	1,708,156	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,017,133					5.00
7.00	00700	OPERATION OF PLANT	417,486	2,047,757				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,714	7,865	109,467			8.00
9.00	00900	HOUSEKEEPING	67,817	56,790	23,081	412,510		9.00
10.00	01000	DIETARY	262,524	151,764	2,027	29,964	1,471,426	10.00
11.00	01100	CAFETERIA	115,139	89,417	0	17,654	0	11.00
13.00	01300	NURSING ADMINISTRATION	202,822	41,375	0	8,169	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,660	32,313	0	6,380	0	14.00
15.00	01500	PHARMACY	120,462	42,913	0	8,473	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,449	90,471	0	17,862	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	691,072	381,234	39,446	75,269	249,961	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	150,102	203,283	8,777	40,135	0	50.00
53.00	05300	ANESTHESIOLOGY	2,303	4,360	0	861	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	320,292	141,363	10,856	27,910	0	54.00
60.00	06000	LABORATORY	297,665	82,122	77	16,214	0	60.00
65.00	06500	RESPIRATORY THERAPY	73,302	10,258	0	2,025	0	65.00
66.00	06600	PHYSICAL THERAPY	171,788	109,078	4,217	21,536	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,242	4,987	0	985	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,451	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,292	7,124	0	1,406	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,062	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,415	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,472	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	8,846	28,124	0	5,553	0	76.01
76.02	03020	PSYCH SERVICES	111,714	62,261	0	12,293	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,052,860	250,812	0	49,519	0	88.00
91.00	09100	EMERGENCY	552,502	86,055	20,848	16,990	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,920,453	1,883,969	109,329	359,198	249,961	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	20,973	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	35,315	9,232	0	1,823	0	194.01
194.02	07952	SENIOR CIRCLE	12,533	18,465	0	3,646	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	47,596	107,967	138	21,317	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	1,221,465	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	1,236	28,124	0	5,553	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,017,133	2,047,757	109,467	412,510	1,471,426	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	671,826					11.00
13.00	01300	NURSING ADMINISTRATION	29,626	1,074,006				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,317	5,787	164,848			14.00
15.00	01500	PHARMACY	12,158	72,365	1,663	728,436		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,387	17,940	523	0	377,728	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	168,676	407,198	22,090	0	44,729	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,652	64,847	12,317	0	32,051	50.00
53.00	05300	ANESTHESIOLOGY	0	0	596	0	894	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,720	0	9,216	0	100,485	54.00
60.00	06000	LABORATORY	46,499	0	37,498	0	79,475	60.00
65.00	06500	RESPIRATORY THERAPY	16,823	45,032	2,123	0	5,037	65.00
66.00	06600	PHYSICAL THERAPY	32,753	0	358	0	21,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,776	0	51	0	7,961	67.00
68.00	06800	SPEECH PATHOLOGY	3,126	0	82	0	1,424	68.00
69.00	06900	ELECTROCARDIOLOGY	4,367	11,840	0	0	8,403	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20,046	0	6,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,939	0	1,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	397	918	0	728,436	12,237	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	397	0	129	0	205	76.01
76.02	03020	PSYCH SERVICES	1,390	0	54	0	2,055	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	171,058	0	36,480	0	15,720	88.00
91.00	09100	EMERGENCY	79,053	448,079	13,144	0	37,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	652,175	1,074,006	164,309	728,436	377,728	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,863	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	2,928	0	75	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	11,860	0	464	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	671,826	1,074,006	164,848	728,436	377,728	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,778,290	0	4,778,290	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,117,309	0	1,117,309	50.00
53.00	05300	ANESTHESIOLOGY	18,009	0	18,009	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,904,574	0	1,904,574	54.00
60.00	06000	LABORATORY	1,721,923	0	1,721,923	60.00
65.00	06500	RESPIRATORY THERAPY	440,842	0	440,842	65.00
66.00	06600	PHYSICAL THERAPY	1,032,403	0	1,032,403	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,386	0	260,386	67.00
68.00	06800	SPEECH PATHOLOGY	90,227	0	90,227	68.00
69.00	06900	ELECTROCARDIOLOGY	78,717	0	78,717	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,297	0	115,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,848	0	74,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,705	0	1,239,705	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	77,799	0	77,799	76.01
76.02	03020	PSYCH SERVICES	626,006	0	626,006	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,687,830	0	5,687,830	88.00
91.00	09100	EMERGENCY	3,411,613	0	3,411,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,675,778	0	22,675,778	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	63,508	0	63,508	192.00
194.00	07950	HOME HEALTH	0	0	0	194.00
194.01	07951	MARKETING	189,136	0	189,136	194.01
194.02	07952	SENIOR CIRCLE	86,587	0	86,587	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	375,204	0	375,204	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	1,431,743	0	1,431,743	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	194.06
194.07	07957	VACANT SPACE	39,740	0	39,740	194.07
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,861,696	0	24,861,696	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,293	22,351	33,644	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	91,358	180,821	272,179	5.00
7.00	00700	OPERATION OF PLANT	0	139,707	276,515	416,222	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,350	2,672	4,022	8.00
9.00	00900	HOUSEKEEPING	0	9,747	19,292	29,039	9.00
10.00	01000	DIETARY	0	26,048	51,555	77,603	10.00
11.00	01100	CAFETERIA	0	15,347	30,376	45,723	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,101	14,055	21,156	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,546	10,977	16,523	14.00
15.00	01500	PHARMACY	0	7,365	14,578	21,943	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,528	30,734	46,262	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	65,433	124,368	189,801	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	34,890	69,057	103,947	50.00
53.00	05300	ANESTHESIOLOGY	0	748	1,481	2,229	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,263	48,022	72,285	54.00
60.00	06000	LABORATORY	0	14,095	27,898	41,993	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,761	3,485	5,246	65.00
66.00	06600	PHYSICAL THERAPY	0	18,722	39,088	57,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	856	4,801	5,657	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,223	2,420	3,643	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	4,827	9,554	14,381	76.01
76.02	03020	PSYCH SERVICES	0	10,686	21,151	31,837	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	43,048	85,203	128,251	88.00
91.00	09100	EMERGENCY	0	14,770	29,233	44,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	565,712	1,119,687	1,685,399	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18,233	0	18,233	192.00
194.00	07950	HOME HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,585	3,136	4,721	194.01
194.02	07952	SENIOR CIRCLE	0	3,169	6,273	9,442	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	18,531	36,677	55,208	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	4,827	0	4,827	194.07
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	612,057	1,165,773	1,777,830	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	274,649					5.00
7.00	00700	OPERATION OF PLANT	22,855	439,596				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,134	1,688	6,844			8.00
9.00	00900	HOUSEKEEPING	3,713	12,191	1,443	46,832		9.00
10.00	01000	DIETARY	14,372	32,579	127	3,402	128,083	10.00
11.00	01100	CAFETERIA	6,303	19,195	0	2,004	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,103	8,882	0	927	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,295	6,937	0	724	0	14.00
15.00	01500	PHARMACY	6,595	9,212	0	962	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,707	19,422	0	2,028	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,832	81,840	2,465	8,544	21,758	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,217	43,639	549	4,557	0	50.00
53.00	05300	ANESTHESIOLOGY	126	936	0	98	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,534	30,347	679	3,169	0	54.00
60.00	06000	LABORATORY	16,295	17,629	5	1,841	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,013	2,202	0	230	0	65.00
66.00	06600	PHYSICAL THERAPY	9,404	23,416	264	2,445	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,641	1,070	0	112	0	67.00
68.00	06800	SPEECH PATHOLOGY	955	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	509	1,529	0	160	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	989	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	734	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,555	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	484	6,038	0	630	0	76.01
76.02	03020	PSYCH SERVICES	6,116	13,366	0	1,396	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	57,629	53,842	0	5,622	0	88.00
91.00	09100	EMERGENCY	30,246	18,474	1,303	1,929	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269,356	404,434	6,835	40,780	21,758	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,381	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,933	1,982	0	207	0	194.01
194.02	07952	SENIOR CIRCLE	686	3,964	0	414	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	2,606	23,178	9	2,420	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	106,325	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	68	6,038	0	630	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	274,649	439,596	6,844	46,832	128,083	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	73,225					11.00
13.00	01300	NURSING ADMINISTRATION	3,229	46,591				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	471	251	26,276			14.00
15.00	01500	PHARMACY	1,325	3,139	265	44,382		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	914	778	83	0	72,427	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,385	17,664	3,521	0	8,579	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,142	2,813	1,963	0	6,147	50.00
53.00	05300	ANESTHESIOLOGY	0	0	95	0	171	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,765	0	1,469	0	19,252	54.00
60.00	06000	LABORATORY	5,068	0	5,978	0	15,244	60.00
65.00	06500	RESPIRATORY THERAPY	1,834	1,953	338	0	966	65.00
66.00	06600	PHYSICAL THERAPY	3,570	0	57	0	4,191	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,066	0	8	0	1,527	67.00
68.00	06800	SPEECH PATHOLOGY	341	0	13	0	273	68.00
69.00	06900	ELECTROCARDIOLOGY	476	514	0	0	1,612	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,195	0	1,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,265	0	212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43	40	0	44,382	2,347	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	43	0	21	0	39	76.01
76.02	03020	PSYCH SERVICES	151	0	9	0	394	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	18,644	0	5,815	0	3,015	88.00
91.00	09100	EMERGENCY	8,616	19,439	2,095	0	7,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,083	46,591	26,190	44,382	72,427	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	530	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	319	0	12	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	1,293	0	74	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	73,225	46,591	26,276	44,382	72,427	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	395,685	0	395,685	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	174,817	0	174,817	50.00
53.00	05300	ANESTHESIOLOGY	3,655	0	3,655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,982	0	150,982	54.00
60.00	06000	LABORATORY	105,582	0	105,582	60.00
65.00	06500	RESPIRATORY THERAPY	17,368	0	17,368	65.00
66.00	06600	PHYSICAL THERAPY	102,459	0	102,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,480	0	12,480	67.00
68.00	06800	SPEECH PATHOLOGY	1,731	0	1,731	68.00
69.00	06900	ELECTROCARDIOLOGY	8,505	0	8,505	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,461	0	5,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,211	0	2,211	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,471	0	52,471	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	21,648	0	21,648	76.01
76.02	03020	PSYCH SERVICES	53,298	0	53,298	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	281,859	0	281,859	88.00
91.00	09100	EMERGENCY	139,113	0	139,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,529,325	0	1,529,325	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,614	0	20,614	192.00
194.00	07950	HOME HEALTH	0	0	0	194.00
194.01	07951	MARKETING	9,550	0	9,550	194.01
194.02	07952	SENIOR CIRCLE	14,916	0	14,916	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	85,060	0	85,060	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	106,802	0	106,802	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	194.06
194.07	07957	VACANT SPACE	11,563	0	11,563	194.07
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,777,830	0	1,777,830	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1348

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

Worksheet B-1

Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	125,147					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		120,432				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,309	2,309	12,667,207			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,680	18,680	929,953	-5,017,133	19,591,750	5.00
7.00	00700	OPERATION OF PLANT	28,566	28,566	195,492	0	1,630,271	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	276	0	0	80,888	8.00
9.00	00900	HOUSEKEEPING	1,993	1,993	168,102	0	264,822	9.00
10.00	01000	DIETARY	5,326	5,326	0	0	1,025,147	10.00
11.00	01100	CAFETERIA	3,138	3,138	0	0	449,616	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	1,452	487,289	0	792,014	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	1,134	28,336	0	92,391	14.00
15.00	01500	PHARMACY	1,506	1,506	354,347	0	470,402	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	3,175	87,844	0	193,096	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,379	12,848	1,993,897	0	2,698,615	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,134	7,134	317,532	0	586,145	50.00
53.00	05300	ANESTHESIOLOGY	153	153	0	0	8,995	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	4,961	558,051	0	1,250,732	54.00
60.00	06000	LABORATORY	2,882	2,882	575,540	0	1,162,373	60.00
65.00	06500	RESPIRATORY THERAPY	360	360	220,506	0	286,242	65.00
66.00	06600	PHYSICAL THERAPY	3,828	4,038	490,304	0	670,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	175	496	150,267	0	188,384	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	55,920	0	68,144	68.00
69.00	06900	ELECTROCARDIOLOGY	250	250	23,352	0	36,285	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	70,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	52,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	39,118	0	396,245	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	987	987	4,444	0	34,545	76.01
76.02	03020	PSYCH SERVICES	2,185	2,185	10,954	0	436,239	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,802	8,802	3,403,247	0	4,111,381	88.00
91.00	09100	EMERGENCY	3,020	3,020	2,194,080	0	2,157,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,671	115,671	12,288,575	-5,017,133	19,214,218	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,728	0	0	-42,535	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	324	324	66,710	0	137,903	194.01
194.02	07952	SENIOR CIRCLE	648	648	29,880	0	48,940	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	3,789	102,286	0	185,862	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	179,756	-210,278	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	987	0	0	0	4,827	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	612,057	1,165,773	1,708,156		5,017,133	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.890705	9.679927	0.134849		0.256084	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			33,644		274,649	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002656		0.014019	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1348

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

Worksheet B-1

Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		OPERATION OF PLANT (NUMBER HOUSED)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	71,864				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	196,627			8.00
9.00	00900	HOUSEKEEPING	1,993	41,459	73,323		9.00
10.00	01000	DIETARY	5,326	3,641	5,326	104,994	10.00
11.00	01100	CAFETERIA	3,138	0	3,138	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	0	1,452	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	0	1,134	0	14.00
15.00	01500	PHARMACY	1,506	0	1,506	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	0	3,175	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,379	70,854	13,379	17,836	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,134	15,765	7,134	0	50.00
53.00	05300	ANESTHESIOLOGY	153	0	153	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	19,500	4,961	0	54.00
60.00	06000	LABORATORY	2,882	138	2,882	0	60.00
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	65.00
66.00	06600	PHYSICAL THERAPY	3,828	7,575	3,828	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	175	0	175	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	250	0	250	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	76.00
76.01	03550	SLEEP LAB	987	0	987	0	76.01
76.02	03020	PSYCH SERVICES	2,185	0	2,185	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,802	0	8,802	0	88.00
91.00	09100	EMERGENCY	3,020	37,448	3,020	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,116	196,380	63,847	17,836	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,728	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING	324	0	324	0	194.01
194.02	07952	SENIOR CIRCLE	648	0	648	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	247	3,789	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	87,158	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07	07957	VACANT SPACE	987	0	987	0	194.07
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,047,757	109,467	412,510	1,471,426	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.494893	0.556724	5.625929	14.014382	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	439,596	6,844	46,832	128,083	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.117054	0.034807	0.638708	1.219908	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1348

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

Worksheet B-1

Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING SA LARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	5,259,012			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,336	813,926		14.00
15.00	01500	PHARMACY	354,347	8,210	338,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	87,844	2,583	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,993,897	109,066	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	317,532	60,814	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,944	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,504	0	54.00
60.00	06000	LABORATORY	0	185,138	0	60.00
65.00	06500	RESPIRATORY THERAPY	220,506	10,483	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,769	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	250	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	407	0	68.00
69.00	06900	ELECTROCARDIOLOGY	57,976	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	98,978	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,198	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,494	0	338,574	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	0	636	0	76.01
76.02	03020	PSYCH SERVICES	0	266	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	180,119	0	88.00
91.00	09100	EMERGENCY	2,194,080	64,900	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,259,012	811,265	338,574	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	372	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	2,289	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	194.07
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,074,006	164,848	728,436	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.204222	0.202534	2.151482	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,591	26,276	44,382	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008859	0.032283	0.131085	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,778,290		4,778,290	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,117,309		1,117,309	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	18,009		18,009	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,904,574		1,904,574	0	0	54.00	
60.00	06000	LABORATORY	1,721,923		1,721,923	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	440,842	0	440,842	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	1,032,403	0	1,032,403	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	260,386	0	260,386	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	90,227	0	90,227	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	78,717		78,717	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,297		115,297	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,848		74,848	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,705		1,239,705	0	0	73.00	
76.00	03610	BLANK	0		0	0	0	76.00	
76.01	03550	SLEEP LAB	77,799		77,799	0	0	76.01	
76.02	03020	PSYCH SERVICES	626,006		626,006	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	5,687,830		5,687,830	0	0	88.00	
91.00	09100	EMERGENCY	3,411,613		3,411,613	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	462,316		462,316		0	92.00	
200.00		Subtotal (see instructions)	23,138,094	0	23,138,094	0	0	200.00	
201.00		Less Observation Beds	462,316		462,316		0	201.00	
202.00		Total (see instructions)	22,675,778	0	22,675,778	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,042,337		13,042,337			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,460,880	9,305,190	10,766,070	0.103781	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	53,003	247,330	300,333	0.059963	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,814,496	30,948,754	33,763,250	0.056410	0.000000	54.00
60.00	06000	LABORATORY	6,149,477	20,546,726	26,696,203	0.064501	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,572,904	118,979	1,691,883	0.260563	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,195,210	3,143,805	7,339,015	0.140673	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,413,311	260,846	2,674,157	0.097371	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	257,109	221,128	478,237	0.188666	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	194,001	2,628,782	2,822,783	0.027886	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,642,253	594,522	2,236,775	0.051546	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,435	344,469	371,904	0.201256	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,272,729	1,837,707	4,110,436	0.301599	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	68,978	68,978	1.127881	0.000000	76.01
76.02	03020	PSYCH SERVICES	900	689,233	690,133	0.907080	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,280,381	5,280,381			88.00
91.00	09100	EMERGENCY	429,800	12,146,062	12,575,862	0.271283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	215,697	1,766,697	1,982,394	0.233211	0.000000	92.00
200.00		Subtotal (see instructions)	36,741,542	90,149,589	126,891,131			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,741,542	90,149,589	126,891,131			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03610 BLANK	0.000000			76.00
76.01	03550 SLEEP LAB	0.000000			76.01
76.02	03020 PSYCH SERVICES	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE	Total Costs		
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,778,290		4,778,290		0	4,778,290	30.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,117,309		1,117,309		0	1,117,309	50.00
53.00	05300	ANESTHESIOLOGY	18,009		18,009		0	18,009	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,904,574		1,904,574		0	1,904,574	54.00
60.00	06000	LABORATORY	1,721,923		1,721,923		0	1,721,923	60.00
65.00	06500	RESPIRATORY THERAPY	440,842	0	440,842		0	440,842	65.00
66.00	06600	PHYSICAL THERAPY	1,032,403	0	1,032,403		0	1,032,403	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,386	0	260,386		0	260,386	67.00
68.00	06800	SPEECH PATHOLOGY	90,227	0	90,227		0	90,227	68.00
69.00	06900	ELECTROCARDIOLOGY	78,717		78,717		0	78,717	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,297		115,297		0	115,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,848		74,848		0	74,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,705		1,239,705		0	1,239,705	73.00
76.00	03610	BLANK	0		0		0	0	76.00
76.01	03550	SLEEP LAB	77,799		77,799		0	77,799	76.01
76.02	03020	PSYCH SERVICES	626,006		626,006		0	626,006	76.02
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,687,830		5,687,830		0	5,687,830	88.00
91.00	09100	EMERGENCY	3,411,613		3,411,613		0	3,411,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	462,316		462,316			462,316	92.00
200.00		Subtotal (see instructions)	23,138,094	0	23,138,094		0	23,138,094	200.00
201.00		Less Observation Beds	462,316		462,316			462,316	201.00
202.00		Total (see instructions)	22,675,778	0	22,675,778		0	22,675,778	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

			Title XIX		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,042,337		13,042,337		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,460,880	9,305,190	10,766,070	0.103781	0.000000
53.00	05300	ANESTHESIOLOGY	53,003	247,330	300,333	0.059963	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,814,496	30,948,754	33,763,250	0.056410	0.000000
60.00	06000	LABORATORY	6,149,477	20,546,726	26,696,203	0.064501	0.000000
65.00	06500	RESPIRATORY THERAPY	1,572,904	118,979	1,691,883	0.260563	0.000000
66.00	06600	PHYSICAL THERAPY	4,195,210	3,143,805	7,339,015	0.140673	0.000000
67.00	06700	OCCUPATIONAL THERAPY	2,413,311	260,846	2,674,157	0.097371	0.000000
68.00	06800	SPEECH PATHOLOGY	257,109	221,128	478,237	0.188666	0.000000
69.00	06900	ELECTROCARDIOLOGY	194,001	2,628,782	2,822,783	0.027886	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,642,253	594,522	2,236,775	0.051546	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,435	344,469	371,904	0.201256	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,272,729	1,837,707	4,110,436	0.301599	0.000000
76.00	03610	BLANK	0	0	0	0.000000	0.000000
76.01	03550	SLEEP LAB	0	68,978	68,978	1.127881	0.000000
76.02	03020	PSYCH SERVICES	900	689,233	690,133	0.907080	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,280,381	5,280,381	1.077163	0.000000
91.00	09100	EMERGENCY	429,800	12,146,062	12,575,862	0.271283	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	215,697	1,766,697	1,982,394	0.233211	0.000000
200.00		Subtotal (see instructions)	36,741,542	90,149,589	126,891,131		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	36,741,542	90,149,589	126,891,131		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.103781			50.00
53.00	05300 ANESTHESIOLOGY	0.059963			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.056410			54.00
60.00	06000 LABORATORY	0.064501			60.00
65.00	06500 RESPIRATORY THERAPY	0.260563			65.00
66.00	06600 PHYSICAL THERAPY	0.140673			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.097371			67.00
68.00	06800 SPEECH PATHOLOGY	0.188666			68.00
69.00	06900 ELECTROCARDIOLOGY	0.027886			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.051546			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.201256			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.301599			73.00
76.00	03610 BLANK	0.000000			76.00
76.01	03550 SLEEP LAB	1.127881			76.01
76.02	03020 PSYCH SERVICES	0.907080			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.077163			88.00
91.00	09100 EMERGENCY	0.271283			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.233211			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,117,309	174,817	942,492	0	0	50.00
53.00	05300	ANESTHESIOLOGY	18,009	3,655	14,354	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,904,574	150,982	1,753,592	0	0	54.00
60.00	06000	LABORATORY	1,721,923	105,582	1,616,341	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	440,842	17,368	423,474	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,032,403	102,459	929,944	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,386	12,480	247,906	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	90,227	1,731	88,496	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	78,717	8,505	70,212	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,297	5,461	109,836	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,848	2,211	72,637	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,705	52,471	1,187,234	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	77,799	21,648	56,151	0	0	76.01
76.02	03020	PSYCH SERVICES	626,006	53,298	572,708	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,687,830	281,859	5,405,971	0	0	88.00
91.00	09100	EMERGENCY	3,411,613	139,113	3,272,500	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	462,316	38,284	424,032	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	18,359,804	1,171,924	17,187,880	0	0	200.00
201.00		Less Observation Beds	462,316	38,284	424,032	0	0	201.00
202.00		Total (line 200 minus line 201)	17,897,488	1,133,640	16,763,848	0	0	202.00

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

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,117,309	10,766,070	0.103781	50.00
53.00	05300	ANESTHESIOLOGY	18,009	300,333	0.059963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,904,574	33,763,250	0.056410	54.00
60.00	06000	LABORATORY	1,721,923	26,696,203	0.064501	60.00
65.00	06500	RESPIRATORY THERAPY	440,842	1,691,883	0.260563	65.00
66.00	06600	PHYSICAL THERAPY	1,032,403	7,339,015	0.140673	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,386	2,674,157	0.097371	67.00
68.00	06800	SPEECH PATHOLOGY	90,227	478,237	0.188666	68.00
69.00	06900	ELECTROCARDIOLOGY	78,717	2,822,783	0.027886	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,297	2,236,775	0.051546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,848	371,904	0.201256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,705	4,110,436	0.301599	73.00
76.00	03610	BLANK	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	77,799	68,978	1.127881	76.01
76.02	03020	PSYCH SERVICES	626,006	690,133	0.907080	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,687,830	5,280,381	1.077163	88.00
91.00	09100	EMERGENCY	3,411,613	12,575,862	0.271283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	462,316	1,982,394	0.233211	92.00
200.00		Subtotal (sum of lines 50 thru 199)	18,359,804	113,848,794		200.00
201.00		Less Observation Beds	462,316	0		201.00
202.00		Total (line 200 minus line 201)	17,897,488	113,848,794		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			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	174,817	10,766,070	0.016238	692,032	11,237	50.00
53.00	05300	ANESTHESIOLOGY	3,655	300,333	0.012170	26,642	324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,982	33,763,250	0.004472	1,211,908	5,420	54.00
60.00	06000	LABORATORY	105,582	26,696,203	0.003955	2,659,793	10,519	60.00
65.00	06500	RESPIRATORY THERAPY	17,368	1,691,883	0.010265	751,960	7,719	65.00
66.00	06600	PHYSICAL THERAPY	102,459	7,339,015	0.013961	857,239	11,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,480	2,674,157	0.004667	158,321	739	67.00
68.00	06800	SPEECH PATHOLOGY	1,731	478,237	0.003620	42,715	155	68.00
69.00	06900	ELECTROCARDIOLOGY	8,505	2,822,783	0.003013	88,630	267	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,461	2,236,775	0.002441	787,560	1,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,211	371,904	0.005945	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,471	4,110,436	0.012765	814,102	10,392	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	21,648	68,978	0.313839	0	0	76.01
76.02	03020	PSYCH SERVICES	53,298	690,133	0.077229	900	70	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	281,859	5,280,381	0.053379	0	0	88.00
91.00	09100	EMERGENCY	139,113	12,575,862	0.011062	38,877	430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,284	1,982,394	0.019312	7,969	154	92.00
200.00		Total (lines 50 through 199)	1,171,924	113,848,794		8,138,648	61,316	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/30/2020 3:35 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/30/2020 3:35 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	10,766,070	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	300,333	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,763,250	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	26,696,203	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,691,883	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,339,015	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,674,157	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	478,237	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,822,783	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,236,775	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	371,904	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,110,436	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	68,978	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	690,133	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,280,381	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,575,862	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,982,394	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	113,848,794		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	692,032	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	26,642	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,211,908	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	2,659,793	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	751,960	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	857,239	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	158,321	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	42,715	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	88,630	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	787,560	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	814,102	0	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	900	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	38,877	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	7,969	0	0	0	92.00
200.00		Total (lines 50 through 199)		8,138,648	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/30/2020 3:35 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.103781	0	2,564,506	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.059963	0	60,392	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.056410	0	10,483,145	0	0	54.00
60.00	06000	LABORATORY	0.064501	0	8,019,799	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.260563	0	35,611	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.140673	0	1,159,807	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097371	0	58,820	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.188666	0	10,487	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027886	0	2,350,588	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.051546	0	114,558	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.201256	0	173,273	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301599	0	602,715	6,549	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	1.127881	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.907080	0	681,694	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.271283	0	3,353,103	1,611	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.233211	0	713,406	0	0	92.00
200.00		Subtotal (see instructions)		0	30,381,904	8,160	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	30,381,904	8,160	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/30/2020 3:35 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	266,147	0					50.00
53.00	05300	ANESTHESIOLOGY	3,621	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	591,354	0					54.00
60.00	06000	LABORATORY	517,285	0					60.00
65.00	06500	RESPIRATORY THERAPY	9,279	0					65.00
66.00	06600	PHYSICAL THERAPY	163,154	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	5,727	0					67.00
68.00	06800	SPEECH PATHOLOGY	1,979	0					68.00
69.00	06900	ELECTROCARDIOLOGY	65,548	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,905	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,872	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181,778	1,975					73.00
76.00	03610	BLANK	0	0					76.00
76.01	03550	SLEEP LAB	0	0					76.01
76.02	03020	PSYCH SERVICES	618,351	0					76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
91.00	09100	EMERGENCY	909,640	437					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	166,374	0					92.00
200.00		Subtotal (see instructions)	3,541,014	2,412					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	3,541,014	2,412					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348

Period:

Worksheet D

Component CCN: 14-Z348

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
11/30/2020 3:35 pm

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.103781	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.059963	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.056410	0	0	0	54.00
60.00	06000	LABORATORY	0.064501	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.260563	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.140673	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.097371	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.188666	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027886	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.051546	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.201256	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301599	0	0	998	73.00
76.00	03610	BLANK	0.000000	0	0	0	76.00
76.01	03550	SLEEP LAB	1.127881	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.907080	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC					88.00
91.00	09100	EMERGENCY	0.271283	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.233211	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	998	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	998	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348

Period:

Worksheet D

Component CCN: 14-Z348

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
11/30/2020 3:35 pm

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	301					73.00
76.00	03610	BLANK	0	0					76.00
76.01	03550	SLEEP LAB	0	0					76.01
76.02	03020	PSYCH SERVICES	0	0					76.02
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC							88.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	301					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	301					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		395,685	219,562	176,123	2,538	69.39	30.00
200.00	Total (lines 30 through 199)		395,685		176,123	2,538		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		18	1,249				
200.00	Total (lines 30 through 199)		18	1,249				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part II Date/Time Prepared: 11/30/2020 3:35 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		174,817	10,766,070	0.016238	0	0	50.00
53.00	05300	ANESTHESIOLOGY		3,655	300,333	0.012170	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		150,982	33,763,250	0.004472	0	0	54.00
60.00	06000	LABORATORY		105,582	26,696,203	0.003955	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		17,368	1,691,883	0.010265	0	0	65.00
66.00	06600	PHYSICAL THERAPY		102,459	7,339,015	0.013961	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		12,480	2,674,157	0.004667	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		1,731	478,237	0.003620	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		8,505	2,822,783	0.003013	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		5,461	2,236,775	0.002441	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		2,211	371,904	0.005945	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		52,471	4,110,436	0.012765	0	0	73.00
76.00	03610	BLANK		0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB		21,648	68,978	0.313839	0	0	76.01
76.02	03020	PSYCH SERVICES		53,298	690,133	0.077229	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		281,859	5,280,381	0.053379	0	0	88.00
91.00	09100	EMERGENCY		139,113	12,575,862	0.011062	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		38,284	1,982,394	0.019312	0	0	92.00
200.00		Total (lines 50 through 199)		1,171,924	113,848,794		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1348		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/30/2020 3:35 pm	
					Title XIX		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	2,538	0.00	18	30.00		
200.00		Total (lines 30 through 199)		0	2,538		18	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1348

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 3:35 pm

				Title XIX		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	10,766,070	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	300,333	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,763,250	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	26,696,203	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,691,883	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,339,015	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,674,157	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	478,237	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,822,783	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,236,775	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	371,904	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,110,436	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	68,978	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	690,133	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,280,381	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,575,862	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,982,394	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	113,848,794		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/30/2020 3:35 pm

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/30/2020 3:35 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,992	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,538	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)		1,981	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		3,164	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		290	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)		1,450	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		2,713	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		157.19	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		157.19	20.00	
21.00	Total general inpatient routine service cost (see instructions)		4,778,290	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)		45,585	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00	
26.00	Total swing-bed cost (see instructions)		2,671,737	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,106,553	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,106,553	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)		830.01	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,203,515	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)		1,203,515	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

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

Worksheet D-1

Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		Title XVIII		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					955,160 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,158,675 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					2,251,817 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,251,817 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					557 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					830.01 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					462,316 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

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

Worksheet D-1

Date/Time Prepared:
11/30/2020 3:35 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	395,685	4,778,290	0.082809	462,316	38,284
91.00	Nursing School cost	0	4,778,290	0.000000	462,316	0
92.00	Allied health cost	0	4,778,290	0.000000	462,316	0
93.00	All other Medical Education	0	4,778,290	0.000000	462,316	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/30/2020 3:35 pm
		Title XIX	Hospital	PPS
Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,992	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,538	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)		1,981	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		3,164	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		290	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)		18	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)		21	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,778,290	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		2,651,432	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,126,858	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,126,858	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)		838.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,084	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)		15,084	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

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

Worksheet D-1

Date/Time Prepared:
11/30/2020 3:35 pm

			Title XIX		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						15,084	49.00
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,249	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						1,249	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						13,835	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						557	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						838.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						466,772	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

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

Worksheet D-1

Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	395,685	4,778,290	0.082809	466,772	38,653
91.00	Nursing School cost	0	4,778,290	0.000000	466,772	0
92.00	Allied health cost	0	4,778,290	0.000000	466,772	0
93.00	All other Medical Education	0	4,778,290	0.000000	466,772	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/30/2020 3:35 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		5,144,056		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.103781	692,032	71,820	50.00
53.00	05300 ANESTHESIOLOGY	0.059963	26,642	1,598	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.056410	1,211,908	68,364	54.00
60.00	06000 LABORATORY	0.064501	2,659,793	171,559	60.00
65.00	06500 RESPIRATORY THERAPY	0.260563	751,960	195,933	65.00
66.00	06600 PHYSICAL THERAPY	0.140673	857,239	120,590	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.097371	158,321	15,416	67.00
68.00	06800 SPEECH PATHOLOGY	0.188666	42,715	8,059	68.00
69.00	06900 ELECTROCARDIOLOGY	0.027886	88,630	2,472	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.051546	787,560	40,596	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.201256	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.301599	814,102	245,532	73.00
76.00	03610 BLANK	0.000000	0	0	76.00
76.01	03550 SLEEP LAB	1.127881	0	0	76.01
76.02	03020 PSYCH SERVICES	0.907080	900	816	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.271283	38,877	10,547	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.233211	7,969	1,858	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,138,648	955,160	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)		8,138,648		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1348 Component CCN: 14-Z348	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/30/2020 3:35 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.103781	76,522	7,942	50.00
53.00	05300 ANESTHESIOLOGY	0.059963	1,145	69	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.056410	225,008	12,693	54.00
60.00	06000 LABORATORY	0.064501	1,506,684	97,183	60.00
65.00	06500 RESPIRATORY THERAPY	0.260563	497,026	129,507	65.00
66.00	06600 PHYSICAL THERAPY	0.140673	2,543,552	357,809	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.097371	1,738,862	169,315	67.00
68.00	06800 SPEECH PATHOLOGY	0.188666	152,124	28,701	68.00
69.00	06900 ELECTROCARDIOLOGY	0.027886	43,220	1,205	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.051546	500,856	25,817	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.201256	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.301599	835,658	252,034	73.00
76.00	03610 BLANK	0.000000	0	0	76.00
76.01	03550 SLEEP LAB	1.127881	0	0	76.01
76.02	03020 PSYCH SERVICES	0.907080	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.271283	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.233211	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,120,657	1,082,275	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		8,120,657		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/30/2020 3:35 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,543,426	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,543,426	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		3,578,860	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		17,370	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,438,347	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)		-876,857	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)		-876,857	30.00
31.00	Primary payer payments		319	31.00
32.00	Subtotal (line 30 minus line 31)		-877,176	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)		605,834	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		393,792	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		392,602	36.00
37.00	Subtotal (see instructions)		-483,384	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		-483,384	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		-1,022,002	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)		538,618	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: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/30/2020 3:35 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,336,924		-1,022,002	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	01/07/2020	99,700		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)		99,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,436,624		-1,022,002	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		338,125		538,618	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,774,749		-483,384	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1348

Period:

Worksheet E-1

Component CCN: 14-Z348

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
11/30/2020 3:35 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,600,179		196	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	01/17/2020	153,400		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)		153,400		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)		2,753,579		196	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		449,093		103	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,202,672		299	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/30/2020 3:35 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2	
		Component CCN: 14-Z348		Date/Time Prepared: 11/30/2020 3:35 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,274,335	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)		1,093,098	304	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		2,713	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)		3,367,433	304	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,367,433	304	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)		3,367,433	304	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		110,368	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		3,257,065	304	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)		3,257,065	304	19.00
19.01	Sequestration adjustment (see instructions)		54,393	5	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		2,753,579	196	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)		449,093	103	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: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 11/30/2020 3:35 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,158,675	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,158,675	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,180,262	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,180,262	19.00
20.00	Deductibles (exclude professional component)		398,552	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,781,710	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,781,710	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		35,663	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		23,181	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		20,650	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,804,891	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,804,891	30.00
30.01	Sequestration adjustment (see instructions)		30,142	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,436,624	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		338,125	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1348

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

Worksheet G

Date/Time Prepared:
11/30/2020 3:35 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	87,427	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	5,940,573	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,834,969	0	0	0	6.00
7.00	Inventory	457,603	0	0	0	7.00
8.00	Prepaid expenses	300,655	0	0	0	8.00
9.00	Other current assets	144,866	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)	5,096,155	0	0	0	11.00
FIXED ASSETS						
12.00	Land	39,727	0	0	0	12.00
13.00	Land improvements	356,121	0	0	0	13.00
14.00	Accumulated depreciation	-179,903	0	0	0	14.00
15.00	Buildings	1,876,771	0	0	0	15.00
16.00	Accumulated depreciation	-1,473,205	0	0	0	16.00
17.00	Leasehold improvements	4,678,761	0	0	0	17.00
18.00	Accumulated depreciation	-2,286,457	0	0	0	18.00
19.00	Fixed equipment	2,582,663	0	0	0	19.00
20.00	Accumulated depreciation	-1,958,041	0	0	0	20.00
21.00	Automobiles and trucks	34,042	0	0	0	21.00
22.00	Accumulated depreciation	-34,042	0	0	0	22.00
23.00	Major movable equipment	4,142,855	0	0	0	23.00
24.00	Accumulated depreciation	-3,533,349	0	0	0	24.00
25.00	Minor equipment depreciable	3,010,005	0	0	0	25.00
26.00	Accumulated depreciation	-2,651,171	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,604,777	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,658,809	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,658,809	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,359,741	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,222,190	0	0	0	37.00
38.00	Salaries, wages, and fees payable	980,884	0	0	0	38.00
39.00	Payroll taxes payable	116,365	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-16,898,654	0	0	0	43.00
44.00	Other current liabilities	3,357,270	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-9,221,945	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-9,221,945	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,581,686				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	20,581,686	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,359,741	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1348

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

Worksheet G-1

Date/Time Prepared:
11/30/2020 3:35 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		19,117,816		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,463,871				2.00
3.00	Total (sum of line 1 and line 2)		20,581,687		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)		20,581,687		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,581,686		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	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1348

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2020 3:35 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	13,368,803		13,368,803	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	13,368,803		13,368,803	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)	13,368,803		13,368,803	17.00
18.00	Ancillary services	23,698,305	0	23,698,305	18.00
19.00	Outpatient services	0	84,543,642	84,543,642	19.00
20.00	RURAL HEALTH CLINIC	0	5,280,381	5,280,381	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	5,485,058	5,485,058	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	37,067,108	95,309,081	132,376,189	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,899,873		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,899,873		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1348

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

Worksheet G-3

Date/Time Prepared:
11/30/2020 3:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	132,376,189	1.00
2.00	Less contractual allowances and discounts on patients' accounts	104,807,787	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,568,402	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,899,873	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-331,471	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	276,046	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	6,488	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	952	17.00
18.00	Revenue from sale of medical records and abstracts	20	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	27,494	22.00
23.00	Governmental appropriations	0	23.00
24.00	COVID GRANT RELIEF FUNDS	1,484,342	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,795,342	25.00
26.00	Total (line 5 plus line 25)	1,463,871	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,463,871	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348

Period:

Worksheet M-1

Component CCN: 14-8514

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 3:35 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,356,977	153,052	1,510,029	0	1,510,029	1.00
2.00	Physician Assistant	223,049	0	223,049	0	223,049	2.00
3.00	Nurse Practitioner	696,310	0	696,310	0	696,310	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	449,722	0	449,722	0	449,722	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	165,883	149,741	315,624	79,041	394,665	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,891,941	302,793	3,194,734	79,041	3,273,775	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	215,952	215,952	0	215,952	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	50,616	50,616	-50,616	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	266,568	266,568	-50,616	215,952	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,891,941	569,361	3,461,302	28,425	3,489,727	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	44,424	44,424	-44,424	0	29.00
30.00	Administrative Costs	511,306	351,534	862,840	-202,456	660,384	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	511,306	395,958	907,264	-246,880	660,384	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,403,247	965,319	4,368,566	-218,455	4,150,111	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348

Period:

Worksheet M-1

Component CCN: 14-8514

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 3:35 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-567,956	942,073	1.00
2.00	Physician Assistant	0	223,049	2.00
3.00	Nurse Practitioner	-13,403	682,907	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	449,722	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	394,665	9.00
10.00	Subtotal (sum of lines 1 through 9)	-581,359	2,692,416	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	215,952	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	215,952	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-581,359	2,908,368	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-44,544	615,840	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-44,544	615,840	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-625,903	3,524,208	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1348

Period:

Worksheet M-2

Component CCN: 14-8514

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/30/2020 3:35 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.51	3,111	1	2		1.00
2.00	Physician Assistant	1.55	430	1	2		2.00
3.00	Nurse Practitioner	5.03	12,093	1	5		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.09	15,634		9	15,634	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)	8.09	15,634			15,634	8.00
9.00	Physician Services Under Agreements		41			41	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)					2,908,368	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,908,368	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					615,840	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,163,622	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,779,462	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,779,462	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,779,462	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,687,830	20.00

Health Financial Systems		RED BUD REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1348	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-8514		Date/Time Prepared: 11/30/2020 3:35 pm	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,687,830	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			43,681	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,644,149	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,634	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			41	5.00
6.00	Total adjusted visits (line 4 plus line 5)			15,675	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			360.07	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)		360.07	360.07	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		3,107	3,106	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		1,118,737	1,118,377	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	2,237,114	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,253,208	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			71,037	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			126,809	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			1,606,234	16.04
16.05	Total program cost (see instructions)		0	1,733,043	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			102,513	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			215,765	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,733,043	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			41,349	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,774,392	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			1,774,392	26.00
26.01	Sequestration adjustment (see instructions)			29,632	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,318,314	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)			426,446	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/30/2020 3:35 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,692,416	2,692,416	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000247	0.000470	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		665	1,265	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		11,233	9,172	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		11,898	10,437	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,908,368	2,908,368	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,779,462	2,779,462	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.004091	0.003589	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		11,371	9,975	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		23,269	20,412	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		115	219	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		202.34	93.21	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		109	207	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		22,055	19,294	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)			43,681	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)			41,349	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/30/2020 3:35 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,134,914	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		01/07/2020	183,400	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)		183,400	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,318,314	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		426,446	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,744,760	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00