

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 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 3:22 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/30/2021	Time: 3:22 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 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ 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) JOHN SCHMIDT

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	291,901	242,824	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	178,560	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		337,344		0	10.00
200.00	Total	0	470,461	580,168	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 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:22 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 2.00	
				Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)
				1.00	2.00	3.00	4.00	5.00	V XVIII XIX 6.00 7.00 8.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	N O P 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF			RED BUD HOSPITAL	14Z348	99914		08/10/2005	N O N 7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								9.00
10.00	Hospital-Based NF								10.00
11.00	Hospital-Based OLTC								11.00
12.00	Hospital-Based HHA								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC			OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	N O N 15.00
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) I								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
								From:	To:
								1.00	2.00
20.00	Cost Reporting Period (mm/dd/yyyy)							07/01/2020	06/30/2021 20.00
21.00	Type of Control (see instructions)							4	21.00
								1.00	2.00 3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 3:22 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1348		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:22 pm		
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
		1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00	
		Y/N	IME	Direct GME	IME	Direct GME		
		1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00		2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20	
						1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
		1.00	2.00	3.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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

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	1.00	
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	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	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete worksheet E, Part A, lines 200 through 218, and worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1348	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:22 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:	98,282	-120,557	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 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:22 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
									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
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
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
		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
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1348	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 3:22 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
			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	07/07/2021	Y	07/07/2021
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 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/30/2021 3:22 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	12/31/2020	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.	CLINTON	BALLEW		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	CBALLEW@QHCUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1348	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 3:22 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 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 3:22 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	59,064.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	59,064.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	59,064.00	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 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 3:22 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)	1,648	21	2,461			1.00
2.00	HMO and other (see instructions)	171	144				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	2,631	0	3,429			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	277			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,279	21	6,167			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)	4,279	21	6,167	0.00	173.71	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,845	0	15,180	0.00	37.44	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	211.15	27.00
28.00	Observation Bed Days		0	347			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 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 3:22 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	418	6	679	1.00
2.00 HMO and other (see instructions)			33	44		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	418	6	679	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 07/01/2020 To 06/30/2021 Worksheet S-8 Date/Time Prepared: 11/30/2021 3:22 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification	325 SPRING STREET			
	Street				
	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	
4.00	Source of Federal Funds				
5.00	Community Health Center (Section 330(d), PHS Act)				
6.00	Migrant Health Center (Section 329(d), PHS Act)				
7.00	Health Services for the Homeless (Section 340(d), PHS Act)				
8.00	Appalachian Regional Commission				
9.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		1.00		2.00	
11.00	Facility hours of operations (1)				
11.00	CLINIC	07:00	07:00	07:00	11.00
		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)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	RANDOLPH			
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		6.00		7.00	8.00
11.00	Facility hours of operations (1)				
11.00	CLINIC	07:00	07:00	07:00	07:00
		07:00		07:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1348 Component CCN: 14-8514		Period: From 07/01/2020 To 06/30/2021	Worksheet S-8 Date/Time Prepared: 11/30/2021 3:22 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		07:00	07:00	08:00	04:00
						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-10

Date/Time Prepared:
11/30/2021 3:22 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)		0.191477	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,485,369	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		15,683,298	6.00
7.00	Medicaid cost (line 1 times line 6)		3,002,991	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)		517,622	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)		517,622	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	718,331	1,472	719,803
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	137,544	1,472	139,016
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)	137,544	1,472	139,016
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,991,726	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		128,714	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		198,021	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,793,705	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		412,760	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		551,776	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,069,398	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1348		Period: From 07/01/2020 To 06/30/2021		Worksheet A Date/Time Prepared: 11/30/2021 3:22 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
			1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT		282,948	282,948	109,724	392,672	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		995,762	995,762	10,567	1,006,329	2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	161,313	45,075	206,388	1,424,707	1,631,095	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,777,948	9,280,569	11,058,517	-1,785,761	9,272,756	5.00	
7.00	00700	OPERATION OF PLANT	250,469	1,090,156	1,340,625	-47,205	1,293,420	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,378	79,378	0	79,378	8.00	
9.00	00900	HOUSEKEEPING	206,113	39,084	245,197	-15,288	229,909	9.00	
10.00	01000	DIETARY	0	886,134	886,134	-479,346	406,788	10.00	
11.00	01100	CAFETERIA	0	0	0	479,346	479,346	11.00	
13.00	01300	NURSING ADMINISTRATION	578,291	204,312	782,603	-42,738	739,865	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	49,556	202,461	252,017	-140,647	111,370	14.00	
15.00	01500	PHARMACY	375,908	833,421	1,209,329	-747,125	462,204	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	557	33,344	33,901	0	33,901	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	2,365,986	414,521	2,780,507	0	2,780,507	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	433,147	186,154	619,301	199	619,500	50.00	
53.00	05300	ANESTHESIOLOGY	0	8,918	8,918	0	8,918	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	578,669	814,775	1,393,444	0	1,393,444	54.00	
60.00	06000	LABORATORY	610,196	563,595	1,173,791	0	1,173,791	60.00	
65.00	06500	RESPIRATORY THERAPY	261,216	89,522	350,738	-19,525	331,213	65.00	
66.00	06600	PHYSICAL THERAPY	550,849	69,467	620,316	0	620,316	66.00	
67.00	06700	OCCUPATIONAL THERAPY	167,090	12,911	180,001	0	180,001	67.00	
68.00	06800	SPEECH PATHOLOGY	62,841	5,989	68,830	0	68,830	68.00	
69.00	06900	ELECTROCARDIOLOGY	19,755	15,348	35,103	3,818	38,921	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	100,373	100,373	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,600	59,600	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	771,919	771,919	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	52,500	409,786	462,286	0	462,286	76.02	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	3,548,290	966,704	4,514,994	95,419	4,610,413	88.00	
91.00	09100	EMERGENCY	2,333,014	816,515	3,149,529	-99,820	3,049,709	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)		14,383,708	18,346,849	32,730,557	-321,783	32,408,774	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	-29,553	-29,553	0	-29,553	192.00	
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00	
194.01	07951	MARKETING	0	0	0	128,205	128,205	194.01	
194.02	07952	SENIOR CIRCLE	7,609	1,373	8,982	0	8,982	194.02	
194.03	07953	RED BUD SPECIALTY CLINIC	221,246	24,065	245,311	-28,612	216,699	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	222,190	222,190	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)		14,612,563	18,342,734	32,955,297	0	32,955,297	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/30/2021 3:22 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	120,305	512,977	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	160,483	1,166,812	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-24,808	1,606,287	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,201,776	7,070,980	5.00
7.00	00700	OPERATION OF PLANT	-23,564	1,269,856	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,378	8.00
9.00	00900	HOUSEKEEPING	0	229,909	9.00
10.00	01000	DIETARY	507,990	914,778	10.00
11.00	01100	CAFETERIA	-79,796	399,550	11.00
13.00	01300	NURSING ADMINISTRATION	0	739,865	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	111,370	14.00
15.00	01500	PHARMACY	0	462,204	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-103	33,798	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-244,715	2,535,792	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	619,500	50.00
53.00	05300	ANESTHESIOLOGY	0	8,918	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-35,808	1,357,636	54.00
60.00	06000	LABORATORY	-62,100	1,111,691	60.00
65.00	06500	RESPIRATORY THERAPY	0	331,213	65.00
66.00	06600	PHYSICAL THERAPY	0	620,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	180,001	67.00
68.00	06800	SPEECH PATHOLOGY	0	68,830	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,921	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	100,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	59,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-129	771,790	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	462,286	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-766,655	3,843,758	88.00
91.00	09100	EMERGENCY	-1,315,429	1,734,280	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)	-3,966,105	28,442,669	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-29,553	192.00
194.00	07950	HOME HEALTH	0	0	194.00
194.01	07951	MARKETING	0	128,205	194.01
194.02	07952	SENIOR CIRCLE	0	8,982	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	216,699	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	222,190	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)	-3,966,105	28,989,192	200.00

RECLASSIFICATIONS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/30/2021 3:22 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	1,452,233	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	95,419	2.00
3.00		0.00	0	0	3.00
			0	1,547,652	
B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	21,756	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
			0	21,756	
D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	109,724	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,567	2.00
			0	120,291	
E - MARKETING COSTS					
1.00	MARKETING	194.01	71,821	56,384	1.00
			71,821	56,384	
F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	78,617	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	59,600	2.00
3.00	OPERATING ROOM	50.00	0	332	3.00
			0	138,549	
G - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	747,125	1.00
			0	747,125	
H - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	0	479,346	1.00
			0	479,346	
I - ALLOCATE NURSING HOME COSTS					
1.00	FREE STANDING NURSING HOME	194.05	215,860	6,330	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
			215,860	6,330	
N - RECLASS OF SPECIALTY CLINIC COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	24,794	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	3,818	0	2.00
			28,612	0	
500.00	Grand Total: Increases		316,293	3,117,433	500.00

RECLASSIFICATIONS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/30/2021 3:22 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,465	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,444,367	0	2.00
3.00	EMERGENCY	91.00	0	99,820	0	3.00
	0		0	1,547,652		
B - OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	133	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,098	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	19,525	0	3.00
	0		0	21,756		
D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	120,291	12	1.00
2.00		0.00	0	0	13	2.00
	0		0	120,291		
E - MARKETING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	71,821	56,384	0	1.00
	0		71,821	56,384		
F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	138,549	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		0	138,549		
G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	747,125	0	1.00
	0		0	747,125		
H - CAFETERIA COSTS						
1.00	DIETARY	10.00	0	479,346	0	1.00
	0		0	479,346		
I - ALLOCATE NURSING HOME COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	24,061	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	89,854	3,044	0	2.00
3.00	OPERATION OF PLANT	7.00	43,919	3,286	0	3.00
4.00	HOUSEKEEPING	9.00	15,288	0	0	4.00
5.00	NURSING ADMINISTRATION	13.00	42,738	0	0	5.00
	0		215,860	6,330		
N - RECLASS OF SPECIALTY CLINIC COSTS						
1.00	RED BUD SPECIALTY CLINIC	194.03	28,612	0	0	1.00
2.00		0.00	0	0	0	2.00
	0		28,612	0		
500.00	Grand Total: Decreases		316,293	3,117,433		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/30/2021 3:22 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	4,730,311	0	0	0	0	3.00	
4.00	Building Improvements	5,027,207	28,562	0	28,562	2,232	4.00	
5.00	Fixed Equipment	2,579,177	0	0	0	9,368	5.00	
6.00	Movable Equipment	12,710,876	3,172,331	0	3,172,331	17,906	6.00	
7.00	HIT designated Assets	3,060,668	2,599,476	0	2,599,476	1,950,357	7.00	
8.00	Subtotal (sum of lines 1-7)	28,419,667	5,800,369	0	5,800,369	1,979,863	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	28,419,667	5,800,369	0	5,800,369	1,979,863	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					
3.00	Buildings and Fixtures	4,730,311	0					
4.00	Building Improvements	5,053,537	0					
5.00	Fixed Equipment	2,569,809	0					
6.00	Movable Equipment	15,865,301	0					
7.00	HIT designated Assets	3,709,787	0					
8.00	Subtotal (sum of lines 1-7)	32,240,173	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	32,240,173	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 3:22 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	282,948	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	995,762	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,278,710	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	282,948				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	995,762				2.00
3.00	Total (sum of lines 1-2)	0	1,278,710				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 3:22 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	12,665,085	0	12,665,085	0.392836	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,575,088	0	19,575,088	0.607164	0	2.00
3.00	Total (sum of lines 1-2)	32,240,173	0	32,240,173	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	305,187	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,125,461	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,430,648	0	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	98,066	109,724	0	0	512,977	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	30,784	0	10,567	0	1,166,812	2.00
3.00	Total (sum of lines 1-2)	128,850	109,724	10,567	0	1,679,789	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/30/2021 3:22 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-13,560	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,401	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	-998,771			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-483,786			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-79,796	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	-129	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-103	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	22,239	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	133,103	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 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/30/2021 3:22 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	-546	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
36.00 COST OF ER PROFESSIONAL BILLING	A	-63,161	EMERGENCY	91.00	0	36.00
38.00 NON RHC COSTS	A	-590,295	RURAL HEALTH CLINIC	88.00	0	38.00
38.03 TELEPHONE SERVICES	A	-3,240	ADMINISTRATIVE & GENERAL	5.00	0	38.03
38.04 NH RADIOLOGY COSTS	A	-2,545	RADIOLOGY-DIAGNOSTIC	54.00	9	38.04
39.00 ADVERTISING	A	-147,737	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01 PROFESSIONAL FEE BENEFITS	A	-584	ADULTS & PEDIATRICS	30.00	0	39.01
39.02 NH LAB COSTS	A	-9,470	LABORATORY	60.00	0	39.02
41.00 PROFESSIONAL FEE BENEFITS	A	-34,085	EMERGENCY	91.00	0	41.00
42.00 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-2,537	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00 LOBBYING EXPENSE	A	-23,869	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
45.01 CRNA COSTS	A	-281,737	EMERGENCY	91.00	0	45.01
45.02 CRNA BENEFITS	A	-23,568	EMERGENCY	91.00	0	45.02
45.03 ILLINOIS PROVIDER TAX	A	-1,206,183	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04 ADD BACK NH CREDIT FOR DIETARY	A	507,990	DIETARY	10.00	0	45.04
45.06 MISCELLANEOUS INCOME	B	-37,620	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07 CHARITABLE CONTRIBUTIONS	A	-1,800	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08 RHC MISC INCOME	B	-176,360	RURAL HEALTH CLINIC	88.00	0	45.08
45.09 PATIENT TV - CABLE EXPENSE	A	-23,564	OPERATION OF PLANT	7.00	0	45.09
45.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.10
45.11 DEPRECIATION ADJ	A	-149,942	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12 PATIENT PHONE DEPRECIATION	A	-1,003	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.12
45.13 MARKETING	A	-2,652	ADMINISTRATIVE & GENERAL	5.00	0	45.13
45.14 HOSPITALIST SALARY	A	-244,131	ADULTS & PEDIATRICS	30.00	0	45.14
45.15 HOSPITALIST BENEFITS	A	-24,262	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.15
45.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.16
45.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.17
45.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.18
45.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.19
45.20 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,966,105				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 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 3:22 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	18,496	0 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	750,658	0 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	85,716	0 3.00
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	30,784	0 4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	591,406	0 4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	98,282	579,840 4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1,491,638 4.03
4.04		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	12,350	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.				1,587,692	2,071,478 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 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 3:22 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	18,496	0		1.00
2.00	750,658	0		2.00
3.00	85,716	11		3.00
4.00	30,784	11		4.00
4.01	591,406	0		4.01
4.02	-481,558	0		4.02
4.03	-1,491,638	0		4.03
4.04	12,350	11		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	-483,786			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 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 3:22 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	54.00	RADIOLOGY-DIAGNOSTIC	33,263	33,263	0	0	0	1.00
2.00	60.00	LABORATORY	52,630	52,630	0	0	0	2.00
3.00	91.00	EMERGENCY	1,800,196	912,878	887,318	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,886,089	998,771	887,318		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	33,263		1.00
2.00	60.00	LABORATORY	0	0	0	52,630		2.00
3.00	91.00	EMERGENCY	0	0	0	912,878		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	998,771		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 3:22 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	512,977	512,977			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,166,812		1,166,812		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,606,287	9,465	22,256	1,638,008	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,070,980	76,569	180,052	182,896	5.00
7.00	00700	OPERATION OF PLANT	1,269,856	117,093	275,343	23,373	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,378	1,131	2,660	0	8.00
9.00	00900	HOUSEKEEPING	229,909	8,169	19,210	21,594	9.00
10.00	01000	DIETARY	914,778	21,831	51,336	0	10.00
11.00	01100	CAFETERIA	399,550	12,863	30,246	0	11.00
13.00	01300	NURSING ADMINISTRATION	739,865	5,952	13,995	60,603	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,370	4,648	10,930	5,608	14.00
15.00	01500	PHARMACY	462,204	6,173	14,516	42,537	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,798	13,014	30,603	63	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,535,792	52,664	123,839	267,733	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	619,500	27,697	65,129	49,014	50.00
53.00	05300	ANESTHESIOLOGY	8,918	627	1,475	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,357,636	20,335	47,818	65,482	54.00
60.00	06000	LABORATORY	1,111,691	11,813	27,779	69,049	60.00
65.00	06500	RESPIRATORY THERAPY	331,213	1,476	3,470	29,559	65.00
66.00	06600	PHYSICAL THERAPY	620,316	18,097	42,555	62,334	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,001	2,033	4,781	18,908	67.00
68.00	06800	SPEECH PATHOLOGY	68,830	0	0	7,111	68.00
69.00	06900	ELECTROCARDIOLOGY	38,921	1,025	2,410	2,667	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100,373	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,600	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	771,790	0	0	2,806	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	462,286	8,956	21,061	5,941	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,843,758	42,675	100,349	401,515	88.00
91.00	09100	EMERGENCY	1,734,280	12,379	29,109	264,002	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)	28,442,669	476,685	1,120,922	1,582,795	28,305,274
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-29,553	15,281	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING	128,205	1,328	3,123	8,127	194.01
194.02	07952	SENIOR CIRCLE	8,982	2,656	6,246	861	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	216,699	15,531	36,521	21,798	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	222,190	0	0	24,427	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	1,496	0	0	194.07
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,989,192	512,977	1,166,812	1,638,008	28,989,192

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,510,497					5.00
7.00	00700	OPERATION OF PLANT	595,876	2,281,541				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,400	8,762	121,331			8.00
9.00	00900	HOUSEKEEPING	98,584	63,274	17,430	458,170		9.00
10.00	01000	DIETARY	349,235	169,090	2,188	33,280	1,541,738	10.00
11.00	01100	CAFETERIA	156,478	99,625	0	19,608	0	11.00
13.00	01300	NURSING ADMINISTRATION	290,013	46,098	0	9,073	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,858	36,002	0	7,086	0	14.00
15.00	01500	PHARMACY	185,737	47,813	0	9,410	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,388	100,800	0	19,839	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,053,428	407,901	41,319	80,283	330,775	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	269,131	214,521	13,382	42,222	0	50.00
53.00	05300	ANESTHESIOLOGY	3,896	4,857	0	956	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	527,158	157,502	14,008	31,000	0	54.00
60.00	06000	LABORATORY	431,382	91,498	94	18,009	0	60.00
65.00	06500	RESPIRATORY THERAPY	129,280	11,429	0	2,250	0	65.00
66.00	06600	PHYSICAL THERAPY	262,754	140,168	7,152	27,588	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,722	15,747	0	3,099	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,845	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15,915	7,937	0	1,562	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,481	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,068	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	273,817	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	176,127	69,369	0	13,653	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,551,244	330,529	0	65,055	0	88.00
91.00	09100	EMERGENCY	721,051	95,879	25,538	18,871	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)	7,350,868	2,118,801	121,111	402,844	330,775	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	23,295	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	49,766	10,286	0	2,025	0	194.01
194.02	07952	SENIOR CIRCLE	6,626	20,573	0	4,049	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	102,708	120,293	220	23,676	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	1,210,963	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	529	11,588	0	2,281	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)	7,510,497	2,281,541	121,331	458,170	1,541,738	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	718,370					11.00
13.00	01300	NURSING ADMINISTRATION	31,095	1,196,694				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,863	10,107	238,472			14.00
15.00	01500	PHARMACY	13,715	76,664	2,858	861,627		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	114	482	0	226,101	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	178,663	482,529	29,009	0	27,478	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,216	88,338	20,863	0	21,848	50.00
53.00	05300	ANESTHESIOLOGY	0	0	772	0	557	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,380	0	10,894	0	55,690	54.00
60.00	06000	LABORATORY	52,714	0	55,075	0	50,917	60.00
65.00	06500	RESPIRATORY THERAPY	21,096	53,273	3,175	0	3,327	65.00
66.00	06600	PHYSICAL THERAPY	38,737	0	497	0	13,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,464	0	46	0	4,783	67.00
68.00	06800	SPEECH PATHOLOGY	4,083	0	48	0	978	68.00
69.00	06900	ELECTROCARDIOLOGY	1,309	4,808	0	0	4,723	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	38,347	0	3,946	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,638	0	835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,460	5,057	0	861,627	9,491	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	4,293	0	166	0	761	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	195,991	0	49,669	0	8,992	88.00
91.00	09100	EMERGENCY	61,980	475,804	12,188	0	18,506	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)	698,059	1,196,694	237,727	861,627	226,101	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	5,235	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	576	0	0	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	14,500	0	745	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)	718,370	1,196,694	238,472	861,627	226,101	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	5,611,413	0	5,611,413	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,459,861	0	1,459,861	50.00
53.00	05300	ANESTHESIOLOGY	22,058	0	22,058	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,333,903	0	2,333,903	54.00
60.00	06000	LABORATORY	1,920,021	0	1,920,021	60.00
65.00	06500	RESPIRATORY THERAPY	589,548	0	589,548	65.00
66.00	06600	PHYSICAL THERAPY	1,233,467	0	1,233,467	66.00
67.00	06700	OCCUPATIONAL THERAPY	313,584	0	313,584	67.00
68.00	06800	SPEECH PATHOLOGY	107,895	0	107,895	68.00
69.00	06900	ELECTROCARDIOLOGY	81,277	0	81,277	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	178,147	0	178,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,141	0	95,141	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,927,048	0	1,927,048	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	76.01
76.02	03020	PSYCH SERVICES	762,613	0	762,613	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,589,777	0	6,589,777	88.00
91.00	09100	EMERGENCY	3,469,587	0	3,469,587	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)	26,695,340	0	26,695,340	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,023	0	9,023	192.00
194.00	07950	HOME HEALTH	0	0	0	194.00
194.01	07951	MARKETING	208,095	0	208,095	194.01
194.02	07952	SENIOR CIRCLE	50,569	0	50,569	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	552,691	0	552,691	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	1,457,580	0	1,457,580	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	194.06
194.07	07957	VACANT SPACE	15,894	0	15,894	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)	28,989,192	0	28,989,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,465	22,256	31,721	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	76,569	180,052	256,621	5.00
7.00	00700	OPERATION OF PLANT	0	117,093	275,343	392,436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,131	2,660	3,791	8.00
9.00	00900	HOUSEKEEPING	0	8,169	19,210	27,379	9.00
10.00	01000	DIETARY	0	21,831	51,336	73,167	10.00
11.00	01100	CAFETERIA	0	12,863	30,246	43,109	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,952	13,995	19,947	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,648	10,930	15,578	14.00
15.00	01500	PHARMACY	0	6,173	14,516	20,689	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,014	30,603	43,617	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	52,664	123,839	176,503	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	27,697	65,129	92,826	50.00
53.00	05300	ANESTHESIOLOGY	0	627	1,475	2,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,335	47,818	68,153	54.00
60.00	06000	LABORATORY	0	11,813	27,779	39,592	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,476	3,470	4,946	65.00
66.00	06600	PHYSICAL THERAPY	0	18,097	42,555	60,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,033	4,781	6,814	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,025	2,410	3,435	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	8,956	21,061	30,017	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	42,675	100,349	143,024	88.00
91.00	09100	EMERGENCY	0	12,379	29,109	41,488	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	476,685	1,120,922	1,597,607	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	15,281	0	15,281	192.00
194.00	07950	HOME HEALTH	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,328	3,123	4,451	194.01
194.02	07952	SENIOR CIRCLE	0	2,656	6,246	8,902	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	15,531	36,521	52,052	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	1,496	0	1,496	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	512,977	1,166,812	1,679,789	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
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To 06/30/2021Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	260,162					5.00
7.00	00700	OPERATION OF PLANT	20,641	413,530				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,018	1,588	6,397			8.00
9.00	00900	HOUSEKEEPING	3,415	11,468	919	43,599		9.00
10.00	01000	DIETARY	12,097	30,648	115	3,167	119,194	10.00
11.00	01100	CAFETERIA	5,420	18,057	0	1,866	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,046	8,355	0	863	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,623	6,525	0	674	0	14.00
15.00	01500	PHARMACY	6,434	8,666	0	895	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	949	18,270	0	1,888	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,490	73,935	2,178	7,639	25,573	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,323	38,882	706	4,018	0	50.00
53.00	05300	ANESTHESIOLOGY	135	880	0	91	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,261	28,547	739	2,950	0	54.00
60.00	06000	LABORATORY	14,943	16,584	5	1,714	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,478	2,072	0	214	0	65.00
66.00	06600	PHYSICAL THERAPY	9,102	25,405	377	2,625	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,519	2,854	0	295	0	67.00
68.00	06800	SPEECH PATHOLOGY	930	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	551	1,439	0	149	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,229	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	730	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,485	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	6,101	12,573	0	1,299	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	53,735	59,908	0	6,191	0	88.00
91.00	09100	EMERGENCY	24,977	17,378	1,346	1,796	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)	254,632	384,034	6,385	38,334	25,573	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	2,217	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,724	1,864	0	193	0	194.01
194.02	07952	SENIOR CIRCLE	230	3,729	0	385	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,558	21,803	12	2,253	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	93,621	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	18	2,100	0	217	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)	260,162	413,530	6,397	43,599	119,194	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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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	68,452					11.00
13.00	01300	NURSING ADMINISTRATION	2,963	43,347				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	559	366	25,434			14.00
15.00	01500	PHARMACY	1,307	2,777	305	41,897		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4	51	0	64,780	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,024	17,479	3,094	0	7,878	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,689	3,200	2,225	0	6,263	50.00
53.00	05300	ANESTHESIOLOGY	0	0	82	0	160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,419	0	1,162	0	15,927	54.00
60.00	06000	LABORATORY	5,023	0	5,874	0	14,597	60.00
65.00	06500	RESPIRATORY THERAPY	2,010	1,930	339	0	954	65.00
66.00	06600	PHYSICAL THERAPY	3,691	0	53	0	3,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,092	0	5	0	1,371	67.00
68.00	06800	SPEECH PATHOLOGY	389	0	5	0	280	68.00
69.00	06900	ELECTROCARDIOLOGY	125	174	0	0	1,354	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,090	0	1,131	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,455	0	239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	234	183	0	41,897	2,721	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	409	0	18	0	218	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	18,676	0	5,297	0	2,578	88.00
91.00	09100	EMERGENCY	5,906	17,234	1,300	0	5,305	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)	66,516	43,347	25,355	41,897	64,780	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	499	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	55	0	0	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	1,382	0	79	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)	68,452	43,347	25,434	41,897	64,780	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1348

Period:
From 07/01/2020
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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	372,977	0	372,977	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	161,081	0	161,081	50.00
53.00	05300	ANESTHESIOLOGY	3,450	0	3,450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,426	0	141,426	54.00
60.00	06000	LABORATORY	99,669	0	99,669	60.00
65.00	06500	RESPIRATORY THERAPY	17,515	0	17,515	65.00
66.00	06600	PHYSICAL THERAPY	106,916	0	106,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,316	0	15,316	67.00
68.00	06800	SPEECH PATHOLOGY	1,742	0	1,742	68.00
69.00	06900	ELECTROCARDIOLOGY	7,279	0	7,279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,450	0	6,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,424	0	2,424	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,574	0	54,574	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	76.01
76.02	03020	PSYCH SERVICES	50,750	0	50,750	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	297,188	0	297,188	88.00
91.00	09100	EMERGENCY	121,842	0	121,842	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)	1,460,599	0	1,460,599	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,498	0	17,498	192.00
194.00	07950	HOME HEALTH	0	0	0	194.00
194.01	07951	MARKETING	8,888	0	8,888	194.01
194.02	07952	SENIOR CIRCLE	13,318	0	13,318	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	81,561	0	81,561	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	94,094	0	94,094	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	194.06
194.07	07957	VACANT SPACE	3,831	0	3,831	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)	1,679,789	0	1,679,789	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
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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		121,054				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,309	2,309	14,475,311			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,680	18,680	1,616,273	-7,510,497	21,246,350	5.00
7.00	00700	OPERATION OF PLANT	28,566	28,566	206,550	0	1,685,665	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	276	0	0	83,169	8.00
9.00	00900	HOUSEKEEPING	1,993	1,993	190,825	0	278,882	9.00
10.00	01000	DIETARY	5,326	5,326	0	0	987,945	10.00
11.00	01100	CAFETERIA	3,138	3,138	0	0	442,659	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	1,452	535,553	0	820,415	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	1,134	49,556	0	132,556	14.00
15.00	01500	PHARMACY	1,506	1,506	375,908	0	525,430	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	3,175	557	0	77,478	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,848	12,848	2,365,986	0	2,980,028	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,757	6,757	433,147	0	761,340	50.00
53.00	05300	ANESTHESIOLOGY	153	153	0	0	11,020	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	4,961	578,669	0	1,491,271	54.00
60.00	06000	LABORATORY	2,882	2,882	610,196	0	1,220,332	60.00
65.00	06500	RESPIRATORY THERAPY	360	360	261,216	0	365,718	65.00
66.00	06600	PHYSICAL THERAPY	4,415	4,415	550,849	0	743,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	496	167,090	0	205,723	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	62,841	0	75,941	68.00
69.00	06900	ELECTROCARDIOLOGY	250	250	23,573	0	45,023	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	100,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	59,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,794	0	774,596	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	2,185	2,185	52,500	0	498,244	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,411	10,411	3,548,290	0	4,388,297	88.00
91.00	09100	EMERGENCY	3,020	3,020	2,333,014	0	2,039,770	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)	116,293	116,293	13,987,387	-7,510,497	20,794,777	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	14,272	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	324	324	71,821	0	140,783	194.01
194.02	07952	SENIOR CIRCLE	648	648	7,609	0	18,745	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	3,789	192,634	0	290,549	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	215,860	-246,617	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	365	0	0	0	1,496	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)	512,977	1,166,812	1,638,008		7,510,497	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.098996	9.638773	0.113159		0.353496	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			31,721		260,162	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002191		0.012245	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 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQ FEET)	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	173,541			8.00
9.00	00900	HOUSEKEEPING	1,993	24,930	73,323		9.00
10.00	01000	DIETARY	5,326	3,129	5,326	86,233	10.00
11.00	01100	CAFETERIA	3,138	0	3,138	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	0	1,452	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	0	1,134	0	14.00
15.00	01500	PHARMACY	1,506	0	1,506	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	0	3,175	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,848	59,099	12,848	18,501	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,757	19,141	6,757	0	50.00
53.00	05300	ANESTHESIOLOGY	153	0	153	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	20,036	4,961	0	54.00
60.00	06000	LABORATORY	2,882	134	2,882	0	60.00
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	65.00
66.00	06600	PHYSICAL THERAPY	4,415	10,230	4,415	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	0	496	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	250	0	250	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	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	10,411	0	10,411	0	88.00
91.00	09100	EMERGENCY	3,020	36,527	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)	66,738	173,226	64,469	18,501	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	315	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	67,732	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	194.06
194.07	07957	VACANT SPACE	365	0	365	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)	2,281,541	121,331	458,170	1,541,738	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.748038	0.699149	6.248653	17.878747	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	413,530	6,397	43,599	119,194	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.754342	0.036862	0.594616	1.382232	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 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:22 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	5,867,751			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,556	1,018,531		14.00
15.00	01500	PHARMACY	375,908	12,208	740,621	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	557	2,060	0	16.00
					139,418,286	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,365,986	123,899	0	30.00
					16,940,867	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	433,147	89,109	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,296	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,531	0	54.00
60.00	06000	LABORATORY	0	235,226	0	60.00
65.00	06500	RESPIRATORY THERAPY	261,216	13,560	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	198	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	207	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,573	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	163,783	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	58,248	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,794	0	740,621	73.00
76.00	03610	BLANK	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	707	0	76.02
					468,915	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	212,141	0	88.00
91.00	09100	EMERGENCY	2,333,014	52,056	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)	5,867,751	1,015,350	740,621	118.00
					139,418,286	
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	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	3,181	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)	1,196,694	238,472	861,627	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.203944	0.234133	1.163385	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,347	25,434	41,897	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007387	0.024971	0.056570	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 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:22 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,611,413		5,611,413	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,459,861		1,459,861	0	0	50.00
53.00	05300	ANESTHESIOLOGY	22,058		22,058	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,333,903		2,333,903	0	0	54.00
60.00	06000	LABORATORY	1,920,021		1,920,021	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	589,548	0	589,548	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,233,467	0	1,233,467	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	313,584	0	313,584	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	107,895	0	107,895	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	81,277		81,277	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	178,147		178,147	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,141		95,141	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,927,048		1,927,048	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	762,613		762,613	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,589,777		6,589,777	0	0	88.00
91.00	09100	EMERGENCY	3,469,587		3,469,587	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,770		309,770	0	0	92.00
200.00		Subtotal (see instructions)	27,005,110	0	27,005,110	0	0	200.00
201.00		Less Observation Beds	309,770		309,770	0	0	201.00
202.00		Total (see instructions)	26,695,340	0	26,695,340	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:22 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	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,851,458		15,851,458			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,566,547	11,903,239	13,469,786	0.108380	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	48,736	294,540	343,276	0.064257	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,587,555	30,768,841	34,356,396	0.067932	0.000000	54.00
60.00	06000	LABORATORY	7,608,608	23,782,583	31,391,191	0.061164	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,856,874	194,183	2,051,057	0.287436	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,128,774	4,052,154	8,180,928	0.150773	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,684,495	264,622	2,949,117	0.106331	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	421,150	181,772	602,922	0.178953	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	271,197	2,640,570	2,911,767	0.027913	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,688,502	744,271	2,432,773	0.073228	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	323	514,453	514,776	0.184820	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,090,757	2,760,808	5,851,565	0.329322	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	468,915	468,915	1.626335	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,543,524	5,543,524			88.00
91.00	09100	EMERGENCY	774,328	10,635,098	11,409,426	0.304098	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	161,539	927,870	1,089,409	0.284347	0.000000	92.00
200.00		Subtotal (see instructions)	43,740,843	95,677,443	139,418,286			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43,740,843	95,677,443	139,418,286			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:22 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 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 3:22 pm	
				Title XIX	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5,611,413		5,611,413	0	5,611,413	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,459,861		1,459,861	0	1,459,861	50.00
53.00	05300 ANESTHESIOLOGY	22,058		22,058	0	22,058	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,333,903		2,333,903	0	2,333,903	54.00
60.00	06000 LABORATORY	1,920,021		1,920,021	0	1,920,021	60.00
65.00	06500 RESPIRATORY THERAPY	589,548	0	589,548	0	589,548	65.00
66.00	06600 PHYSICAL THERAPY	1,233,467	0	1,233,467	0	1,233,467	66.00
67.00	06700 OCCUPATIONAL THERAPY	313,584	0	313,584	0	313,584	67.00
68.00	06800 SPEECH PATHOLOGY	107,895	0	107,895	0	107,895	68.00
69.00	06900 ELECTROCARDIOLOGY	81,277		81,277	0	81,277	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	178,147		178,147	0	178,147	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	95,141		95,141	0	95,141	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,927,048		1,927,048	0	1,927,048	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	762,613		762,613	0	762,613	76.02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	6,589,777		6,589,777	0	6,589,777	88.00
91.00	09100 EMERGENCY	3,469,587		3,469,587	0	3,469,587	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	309,770		309,770	0	309,770	92.00
200.00	Subtotal (see instructions)	27,005,110	0	27,005,110	0	27,005,110	200.00
201.00	Less Observation Beds	309,770		309,770		309,770	201.00
202.00	Total (see instructions)	26,695,340	0	26,695,340	0	26,695,340	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:22 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	15,851,458		15,851,458			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,566,547	11,903,239	13,469,786	0.108380	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	48,736	294,540	343,276	0.064257	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,587,555	30,768,841	34,356,396	0.067932	0.000000	54.00
60.00	06000	LABORATORY	7,608,608	23,782,583	31,391,191	0.061164	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,856,874	194,183	2,051,057	0.287436	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,128,774	4,052,154	8,180,928	0.150773	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,684,495	264,622	2,949,117	0.106331	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	421,150	181,772	602,922	0.178953	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	271,197	2,640,570	2,911,767	0.027913	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,688,502	744,271	2,432,773	0.073228	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	323	514,453	514,776	0.184820	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,090,757	2,760,808	5,851,565	0.329322	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	468,915	468,915	1.626335	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,543,524	5,543,524	1.188734	0.000000	88.00
91.00	09100	EMERGENCY	774,328	10,635,098	11,409,426	0.304098	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	161,539	927,870	1,089,409	0.284347	0.000000	92.00
200.00		Subtotal (see instructions)	43,740,843	95,677,443	139,418,286			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43,740,843	95,677,443	139,418,286			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:22 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	0.108380			50.00
53.00	05300 ANESTHESIOLOGY	0.064257			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.067932			54.00
60.00	06000 LABORATORY	0.061164			60.00
65.00	06500 RESPIRATORY THERAPY	0.287436			65.00
66.00	06600 PHYSICAL THERAPY	0.150773			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.106331			67.00
68.00	06800 SPEECH PATHOLOGY	0.178953			68.00
69.00	06900 ELECTROCARDIOLOGY	0.027913			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.073228			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.184820			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329322			73.00
76.00	03610 BLANK	0.000000			76.00
76.01	03550 SLEEP LAB	0.000000			76.01
76.02	03020 PSYCH SERVICES	1.626335			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.188734			88.00
91.00	09100 EMERGENCY	0.304098			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.284347			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 07/01/2020
To 06/30/2021Worksheet C
Part II
Date/Time Prepared:
11/30/2021 3:22 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	1,459,861	161,081	1,298,780	0	0
53.00	05300	ANESTHESIOLOGY	22,058	3,450	18,608	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,333,903	141,426	2,192,477	0	0
60.00	06000	LABORATORY	1,920,021	99,669	1,820,352	0	0
65.00	06500	RESPIRATORY THERAPY	589,548	17,515	572,033	0	0
66.00	06600	PHYSICAL THERAPY	1,233,467	106,916	1,126,551	0	0
67.00	06700	OCCUPATIONAL THERAPY	313,584	15,316	298,268	0	0
68.00	06800	SPEECH PATHOLOGY	107,895	1,742	106,153	0	0
69.00	06900	ELECTROCARDIOLOGY	81,277	7,279	73,998	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	178,147	6,450	171,697	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,141	2,424	92,717	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,927,048	54,574	1,872,474	0	0
76.00	03610	BLANK	0	0	0	0	0
76.01	03550	SLEEP LAB	0	0	0	0	0
76.02	03020	PSYCH SERVICES	762,613	50,750	711,863	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,589,777	297,188	6,292,589	0	0
91.00	09100	EMERGENCY	3,469,587	121,842	3,347,745	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,770	20,590	289,180	0	0
200.00		Subtotal (sum of lines 50 thru 199)	21,393,697	1,108,212	20,285,485	0	0
201.00		Less Observation Beds	309,770	20,590	289,180	0	0
202.00		Total (line 200 minus line 201)	21,083,927	1,087,622	19,996,305	0	0

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

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part II
Date/Time Prepared:
11/30/2021 3:22 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	1,459,861	13,469,786	0.108380	50.00
53.00	05300	ANESTHESIOLOGY	22,058	343,276	0.064257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,333,903	34,356,396	0.067932	54.00
60.00	06000	LABORATORY	1,920,021	31,391,191	0.061164	60.00
65.00	06500	RESPIRATORY THERAPY	589,548	2,051,057	0.287436	65.00
66.00	06600	PHYSICAL THERAPY	1,233,467	8,180,928	0.150773	66.00
67.00	06700	OCCUPATIONAL THERAPY	313,584	2,949,117	0.106331	67.00
68.00	06800	SPEECH PATHOLOGY	107,895	602,922	0.178953	68.00
69.00	06900	ELECTROCARDIOLOGY	81,277	2,911,767	0.027913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	178,147	2,432,773	0.073228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,141	514,776	0.184820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,927,048	5,851,565	0.329322	73.00
76.00	03610	BLANK	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	762,613	468,915	1.626335	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,589,777	5,543,524	1.188734	88.00
91.00	09100	EMERGENCY	3,469,587	11,409,426	0.304098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,770	1,089,409	0.284347	92.00
200.00		Subtotal (sum of lines 50 thru 199)	21,393,697	123,566,828		200.00
201.00		Less Observation Beds	309,770	0		201.00
202.00		Total (line 200 minus line 201)	21,083,927	123,566,828		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/30/2021 3:22 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	161,081	13,469,786	0.011959	615,104	7,356	50.00
53.00	05300	ANESTHESIOLOGY	3,450	343,276	0.010050	17,530	176	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,426	34,356,396	0.004116	1,595,037	6,565	54.00
60.00	06000	LABORATORY	99,669	31,391,191	0.003175	2,973,245	9,440	60.00
65.00	06500	RESPIRATORY THERAPY	17,515	2,051,057	0.008539	848,252	7,243	65.00
66.00	06600	PHYSICAL THERAPY	106,916	8,180,928	0.013069	832,600	10,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,316	2,949,117	0.005193	234,248	1,216	67.00
68.00	06800	SPEECH PATHOLOGY	1,742	602,922	0.002889	73,209	212	68.00
69.00	06900	ELECTROCARDIOLOGY	7,279	2,911,767	0.002500	75,122	188	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,450	2,432,773	0.002651	711,015	1,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,424	514,776	0.004709	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,574	5,851,565	0.009326	1,117,633	10,423	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	50,750	468,915	0.108229	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	297,188	5,543,524	0.053610	0	0	88.00
91.00	09100	EMERGENCY	121,842	11,409,426	0.010679	90,515	967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	20,590	1,089,409	0.018900	0	0	92.00
200.00		Total (lines 50 through 199)	1,108,212	123,566,828		9,183,510	56,552	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1348		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:22 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 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 3:22 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	13,469,786	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	343,276	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,356,396	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	31,391,191	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,051,057	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,180,928	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,949,117	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	602,922	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,911,767	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,432,773	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	514,776	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,851,565	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	468,915	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,543,524	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,409,426	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,089,409	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	123,566,828		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 3:22 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	615,104	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	17,530	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,595,037	0	0	0
60.00	06000	LABORATORY	0.000000	2,973,245	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	848,252	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	832,600	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	234,248	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	73,209	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	75,122	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	711,015	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,117,633	0	0	0
76.00	03610	BLANK	0.000000	0	0	0	0
76.01	03550	SLEEP LAB	0.000000	0	0	0	0
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	90,515	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		9,183,510	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/30/2021 3:22 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	0.108380	0	2,947,033	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.064257	0	62,884	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.067932	0	10,741,086	0	0	54.00	
60.00	06000	LABORATORY	0.061164	0	8,264,799	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.287436	0	69,035	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.150773	0	1,371,849	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.106331	0	85,689	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.178953	0	16,623	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.027913	0	1,770,212	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.073228	0	150,811	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.184820	0	272,836	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.329322	0	1,434,427	3,355	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	1.626335	0	439,251	0	0	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00	
91.00	09100	EMERGENCY	0.304098	0	2,848,956	1,136	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284347	0	468,843	0	0	92.00	
200.00		Subtotal (see instructions)		0	30,944,334	4,491	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	30,944,334	4,491	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/30/2021 3:22 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	319,399	0		50.00
53.00	05300	ANESTHESIOLOGY	4,041	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	729,663	0		54.00
60.00	06000	LABORATORY	505,508	0		60.00
65.00	06500	RESPIRATORY THERAPY	19,843	0		65.00
66.00	06600	PHYSICAL THERAPY	206,838	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,111	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,975	0		68.00
69.00	06900	ELECTROCARDIOLOGY	49,412	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,044	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,426	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	472,388	1,105		73.00
76.00	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	714,369	0		76.02
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	866,362	345		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	133,314	0		92.00
200.00		Subtotal (see instructions)	4,094,693	1,450		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,094,693	1,450		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/30/2021 3:22 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		372,977	205,057	167,920	2,808	59.80	30.00
200.00	Total (lines 30 through 199)		372,977		167,920	2,808		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		21	1,256				
200.00	Total (lines 30 through 199)		21	1,256				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1348		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part II Date/Time Prepared: 11/30/2021 3:22 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		161,081	13,469,786	0.011959	0	0	50.00
53.00	05300	ANESTHESIOLOGY		3,450	343,276	0.010050	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		141,426	34,356,396	0.004116	0	0	54.00
60.00	06000	LABORATORY		99,669	31,391,191	0.003175	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		17,515	2,051,057	0.008539	0	0	65.00
66.00	06600	PHYSICAL THERAPY		106,916	8,180,928	0.013069	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		15,316	2,949,117	0.005193	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		1,742	602,922	0.002889	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		7,279	2,911,767	0.002500	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		6,450	2,432,773	0.002651	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		2,424	514,776	0.004709	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		54,574	5,851,565	0.009326	0	0	73.00
76.00	03610	BLANK		0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB		0	0	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES		50,750	468,915	0.108229	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		297,188	5,543,524	0.053610	0	0	88.00
91.00	09100	EMERGENCY		121,842	11,409,426	0.010679	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		20,590	1,089,409	0.018900	0	0	92.00
200.00		Total (lines 50 through 199)		1,108,212	123,566,828		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1348		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/30/2021 3:22 pm		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	2,808	0.00	21			30.00	
200.00		Total (lines 30 through 199)	0	0	2,808		21			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 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 3:22 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 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 3:22 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	13,469,786	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	343,276	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,356,396	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	31,391,191	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,051,057	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,180,928	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,949,117	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	602,922	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,911,767	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,432,773	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	514,776	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,851,565	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	468,915	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,543,524	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,409,426	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,089,409	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	123,566,828		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 3:22 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 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:22 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)	6,514	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,808	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,461	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)	3,429	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	138	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)	139	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,648	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)	2,631	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)	5,611,413	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)	21,692	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)	21,849	25.00	
26.00	Total swing-bed cost (see instructions)	3,104,678	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,506,735	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)	2,506,735	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)	892.72	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,471,203	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)	1,471,203	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/30/2021 3:22 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)					1,215,111 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,686,314 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					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)					2,348,746 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,348,746 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)					347 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					892.71 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					309,770 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/30/2021 3:22 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	372,977	5,611,413	0.066468	309,770	20,590
91.00	Nursing School cost	0	5,611,413	0.000000	309,770	0
92.00	Allied health cost	0	5,611,413	0.000000	309,770	0
93.00	All other Medical Education	0	5,611,413	0.000000	309,770	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1348	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:22 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,514	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,808	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,461	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)		3,429	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		277	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		21	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,611,413	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)		3,085,071	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,526,342	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)		2,526,342	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)		899.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		18,893	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)		18,893	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/30/2021 3:22 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)					18,893	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)					1,256	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)					1,256	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,637	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)					347	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					899.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					312,192	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/30/2021 3:22 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	372,977	5,611,413	0.066468	312,192	20,751 90.00
91.00	Nursing School cost	0	5,611,413	0.000000	312,192	0 91.00
92.00	Allied health cost	0	5,611,413	0.000000	312,192	0 92.00
93.00	All other Medical Education	0	5,611,413	0.000000	312,192	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1348	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 3:22 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		5,174,708		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.108380	615,104	66,665	50.00
53.00	05300 ANESTHESIOLOGY	0.064257	17,530	1,126	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.067932	1,595,037	108,354	54.00
60.00	06000 LABORATORY	0.061164	2,973,245	181,856	60.00
65.00	06500 RESPIRATORY THERAPY	0.287436	848,252	243,818	65.00
66.00	06600 PHYSICAL THERAPY	0.150773	832,600	125,534	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.106331	234,248	24,908	67.00
68.00	06800 SPEECH PATHOLOGY	0.178953	73,209	13,101	68.00
69.00	06900 ELECTROCARDIOLOGY	0.027913	75,122	2,097	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.073228	711,015	52,066	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.184820	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329322	1,117,633	368,061	73.00
76.00	03610 BLANK	0.000000	0	0	76.00
76.01	03550 SLEEP LAB	0.000000	0	0	76.01
76.02	03020 PSYCH SERVICES	1.626335	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.304098	90,515	27,525	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.284347	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		9,183,510	1,215,111	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)		9,183,510		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1348 Component CCN: 14-Z348	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 3:22 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				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.108380	165,727	17,961	50.00
53.00	05300 ANESTHESIOLOGY	0.064257	14,144	909	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.067932	162,489	11,038	54.00
60.00	06000 LABORATORY	0.061164	1,498,891	91,678	60.00
65.00	06500 RESPIRATORY THERAPY	0.287436	287,598	82,666	65.00
66.00	06600 PHYSICAL THERAPY	0.150773	2,352,709	354,725	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.106331	1,743,510	185,389	67.00
68.00	06800 SPEECH PATHOLOGY	0.178953	247,170	44,232	68.00
69.00	06900 ELECTROCARDIOLOGY	0.027913	12,754	356	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.073228	366,056	26,806	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.184820	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.329322	759,520	250,127	73.00
76.00	03610 BLANK	0.000000	0	0	76.00
76.01	03550 SLEEP LAB	0.000000	0	0	76.01
76.02	03020 PSYCH SERVICES	1.626335	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.304098	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.284347	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,610,568	1,065,887	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		7,610,568		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1348	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 3:22 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,096,143 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)			4,096,143 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			4,137,104 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)			26,443 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			4,433,667 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)			-323,006 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)			-323,006 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			-323,006 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)			178,187 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			115,822 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			59,648 36.00
37.00	Subtotal (see instructions)			-207,184 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)			-207,184 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			-450,008 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)			242,824 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 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/30/2021 3:22 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		1,841,548		-617,908	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	01/13/2021	183,800	01/13/2021	167,900	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)		183,800		167,900	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)		2,025,348		-450,008	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		291,901		242,824	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,317,249		-207,184	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 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 3:22 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		2,914,039		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/13/2021	230,000		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)		230,000		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)		3,144,039		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		178,560		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,322,599		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/30/2021 3:22 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 07/01/2020 To 06/30/2021	Worksheet E-2	
		Component CCN: 14-Z348		Date/Time Prepared: 11/30/2021 3:22 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)		2,372,233	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)		1,076,546	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		2,631	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)		3,448,779	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,448,779	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		3,448,779	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		126,180	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		3,322,599	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		3,322,599	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		3,144,039	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		178,560	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1348	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/30/2021 3:22 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,686,314	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,686,314	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,713,177	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)		2,713,177	19.00
20.00	Deductibles (exclude professional component)		408,116	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,305,061	22.00
23.00	Coinsurance		704	23.00
24.00	Subtotal (line 22 minus line 23)		2,304,357	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		19,834	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		12,892	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,941	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,317,249	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)		2,317,249	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,025,348	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)		291,901	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 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/30/2021 3:22 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	-210,376	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	5,043,974	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,709,473	0	0	0	6.00
7.00	Inventory	527,810	0	0	0	7.00
8.00	Prepaid expenses	400,862	0	0	0	8.00
9.00	Other current assets	144,012	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)	4,196,809	0	0	0	11.00
FIXED ASSETS						
12.00	Land	210,000	0	0	0	12.00
13.00	Land improvements	170,963	0	0	0	13.00
14.00	Accumulated depreciation	-24,423	0	0	0	14.00
15.00	Buildings	5,237,166	0	0	0	15.00
16.00	Accumulated depreciation	-252,874	0	0	0	16.00
17.00	Leasehold improvements	56,968	0	0	0	17.00
18.00	Accumulated depreciation	-5,651	0	0	0	18.00
19.00	Fixed equipment	276,818	0	0	0	19.00
20.00	Accumulated depreciation	-91,031	0	0	0	20.00
21.00	Automobiles and trucks	4,209	0	0	0	21.00
22.00	Accumulated depreciation	-1,684	0	0	0	22.00
23.00	Major movable equipment	1,512,786	0	0	0	23.00
24.00	Accumulated depreciation	-260,768	0	0	0	24.00
25.00	Minor equipment depreciable	887,048	0	0	0	25.00
26.00	Accumulated depreciation	-193,901	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)	7,525,626	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	3,406,480	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,406,480	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,128,915	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,078,172	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,036,707	0	0	0	38.00
39.00	Payroll taxes payable	456,160	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	9,138,004	0	0	0	43.00
44.00	Other current liabilities	1,453,955	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,162,998	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)	15,162,998	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-34,083	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-34,083	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,128,915	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/30/2021 3:22 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		20,581,686		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-34,083				2.00
3.00	Total (sum of line 1 and line 2)		20,547,603		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)		20,547,603		0		11.00
12.00	REORGANIZATION ADJUSTMENTS TO RE	20,581,686		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)		20,581,686		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-34,083		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	REORGANIZATION ADJUSTMENTS TO RE		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 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2021 3:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	16,064,085		16,064,085	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)	16,064,085		16,064,085	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)	16,064,085		16,064,085	17.00
18.00	Ancillary services	26,953,518	78,570,951	105,524,469	18.00
19.00	Outpatient services	935,867	11,562,968	12,498,835	19.00
20.00	RURAL HEALTH CLINIC	0	5,543,524	5,543,524	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES AND OTHER	0	5,170,343	5,170,343	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	43,953,470	100,847,786	144,801,256	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,955,297		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,955,297		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1348

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/30/2021 3:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	144,801,256	1.00
2.00	Less contractual allowances and discounts on patients' accounts	112,873,969	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,927,287	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,955,297	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,028,010	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	79,796	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	103	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	412,788	24.00
24.50	COVID-19 PHE Funding	525,328	24.50
25.00	Total other income (sum of lines 6-24)	1,018,015	25.00
26.00	Total (line 5 plus line 25)	-9,995	26.00
27.00	GAIN LOSS ON DISPOSAL ON ASSETS	24,088	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	24,088	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-34,083	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348

Period:

Worksheet M-1

Component CCN: 14-8514

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 3:22 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,282,574	14,948	1,297,522	0	1,297,522	1.00
2.00	Physician Assistant	249,711	0	249,711	0	249,711	2.00
3.00	Nurse Practitioner	757,325	0	757,325	0	757,325	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	545,646	0	545,646	0	545,646	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	43,888	0	43,888	0	43,888	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	208,953	154,271	363,224	95,419	458,643	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,088,097	169,219	3,257,316	95,419	3,352,735	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	243,247	243,247	0	243,247	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	0	50,616	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	293,863	293,863	0	293,863	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,088,097	463,082	3,551,179	95,419	3,646,598	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	49,764	49,764	0	49,764	29.00
30.00	Administrative Costs	460,193	453,858	914,051	0	914,051	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	460,193	503,622	963,815	0	963,815	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,548,290	966,704	4,514,994	95,419	4,610,413	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348

Period:

Worksheet M-1

Component CCN: 14-8514

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 3:22 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	-477,090	820,432	1.00
2.00	Physician Assistant	-10,790	238,921	2.00
3.00	Nurse Practitioner	-49,053	708,272	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	545,646	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	43,888	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	-53,362	405,281	9.00
10.00	Subtotal (sum of lines 1 through 9)	-590,295	2,762,440	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	243,247	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	50,616	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	293,863	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-590,295	3,056,303	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	49,764	29.00
30.00	Administrative Costs	-176,360	737,691	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-176,360	787,455	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-766,655	3,843,758	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1348 Component CCN: 14-8514		Period: From 07/01/2020 To 06/30/2021		Worksheet M-2 Date/Time Prepared: 11/30/2021 3:22 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	1.13	3,238	1	1			1.00
2.00	Physician Assistant	1.07	3,722	1	1			2.00
3.00	Nurse Practitioner	4.62	8,220	1	5			3.00
4.00	Subtotal (sum of lines 1 through 3)	6.82	15,180		7		15,180	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)	6.82	15,180				15,180	8.00
9.00	Physician Services Under Agreements		0				0	9.00
							1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES								
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)						3,056,303	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)						3,056,303	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)						787,455	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						2,746,019	15.00
16.00	Total overhead (sum of lines 14 and 15)						3,533,474	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						3,533,474	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						3,533,474	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						6,589,777	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 07/01/2020 To 06/30/2021	Worksheet M-3	
		Component CCN: 14-8514		Date/Time Prepared: 11/30/2021 3:22 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)			6,589,777	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			48,165	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			6,541,612	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,180	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			15,180	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			430.94	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)	86.31	87.52	365.11	8.00
9.00	Rate for Program covered visits (see instructions)	430.94	430.94	365.11	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	2,877	1,387	1,501	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,239,814	597,714	548,030	11.00
12.00	Program covered visits for mental health services (from contractor records)	17	20	43	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	7,326	8,619	15,700	13.00
14.00	Limit adjustment for mental health services (see instructions)	7,326	8,619	15,700	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	2,417,203		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,226,857		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		112,804		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		222,252		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.)		1,686,292		16.04
16.05	Total program cost (see instructions)	0	1,908,544		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		87,086		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		205,394		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,908,544		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		40,960		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,949,504		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)		1,949,504		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,612,160		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)		337,344		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1348

Period:

Worksheet M-4

Component CCN: 14-8514

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 3:22 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,762,440	2,762,440	2,762,440	2,762,440	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000247	0.000470	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	682	1,298	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	13,811	6,548	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	14,493	7,846	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,056,303	3,056,303	3,056,303	3,056,303	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,533,474	3,533,474	3,533,474	3,533,474	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004742	0.002567	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	16,756	9,070	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31,249	16,916	0	0	10.00
11.00	Total number of injections/infusions (from your records)	360	67	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	86.80	252.48	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	277	67	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	24,044	16,916	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		48,165			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		40,960			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 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 11/30/2021 3:22 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		1,455,160	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		01/13/2021	157,000		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)		157,000		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,612,160		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		337,344		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,949,504		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00