

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet S
Parts I-III
Date/Time Prepared:
3/31/2020 9:55 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 3/31/2020	Time: 9:55 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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 PARIS COMMUNITY HOSPITAL (14-1320) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) OLIVER SMITH

Officer or Administrator of Provider(s)

CEO

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	-328,423	709,011	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	-242,485	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		857,018		0	10.00
10.01	RURAL HEALTH CLINIC II	0		24,137		0	10.01
10.02	RURAL HEALTH CLINIC III	0		97,187		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		14,892		0	10.03
10.04	RURAL HEALTH CLINIC V	0		74		0	10.04
200.00	Total	0	-570,908	1,702,319	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: 14-1320		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 3/31/2020 9:55 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 721 EAST COURT STREET			PO Box:				1.00		
2.00	City: PARIS			State: IL		Zip Code: 61944-		County: EDGAR		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		PARIS COMMUNITY HOSPITAL	141320	99914	1	06/30/2002	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		PARIS COMMUNITY HOSPITAL	14Z320	99914		06/30/2002	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		FMC	143987	99914		09/24/1994	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		HATCH	143989	99914		01/01/1995	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		FMC OAKLAND	148596	99914		02/22/2019	N	O	N
15.03	Hospital-Based Health Clinic - RHC IV		HOSPITAL & MEDICAL FOUNDATION OF PAR	148607	99914		10/25/2019	N	O	N
15.04	Hospital-Based Health Clinic - RHC V		VEZ CARE MARSHALL	148606	99914		11/14/2019	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
3/31/2020 9:55 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1320		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 3/31/2020 9:55 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
			1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N			60.00		
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).							61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
			1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20	
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00	
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 3/31/2020 9:55 am	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
						1.00	2.00
						1.00	2.00
						1.00	2.00
115.00	Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	225,110		0		0	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N					122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 3/31/2020 9:55 am	
		1.00		2.00			
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)	N				140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
				3.00		4.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 3/31/2020 9:55 am
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1320		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 3/31/2020 9:55 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	03/02/2020	N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		Y	03/02/2020 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
3/31/2020 9:55 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508	SADAMS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
3/31/2020 9:55 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	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: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/31/2020 9:55 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 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	47,376.00	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	47,376.00	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	47,376.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
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: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/31/2020 9:55 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,170	42	1,974		1.00
2.00	HMO and other (see instructions)	137	126			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	767	0	1,040		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2,103		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,937	42	5,117		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)	1,937	42	5,117	0.00	333.72
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RURAL HEALTH CLINIC	13,434	0	44,177	0.00	81.36
26.01	RURAL HEALTH CLINIC II	431	0	2,687	0.00	4.75
26.02	RURAL HEALTH CLINIC III	669	0	2,120	0.00	3.22
26.03	RURAL HEALTH CLINIC IV	93	0	1,708	0.00	2.58
26.04	RURAL HEALTH CLINIC V	1	0	384	0.00	0.37
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	426.00
28.00	Observation Bed Days		0	781		27.00
29.00	Ambulance Trips	0				28.00
30.00	Employee discount days (see instruction)			0		29.00
31.00	Employee discount days - IRF			0		30.00
32.00	Labor & delivery days (see instructions)	0	0	0		31.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.00
33.00	LTCH non-covered days	0				32.01
33.01	LTCH site neutral days and discharges	0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/31/2020 9:55 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	376	17	620	1.00
2.00 HMO and other (see instructions)			42	51		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	376	17	620	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.04 RURAL HEALTH CLINIC V	0.00					26.04
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		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1320 Component CCN: 14-3987		Period: From 01/01/2019 To 12/31/2019 Worksheet S-8 Date/Time Prepared: 3/31/2020 9:55 am		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	727 EAST COURT STREET				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	PARIS		IL	61944	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					4.00
5.00	Community Health Center (Section 330(d), PHS Act)					5.00
6.00	Migrant Health Center (Section 329(d), PHS Act)					6.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)					7.00
8.00	Appalachian Regional Commission					8.00
9.00	Look-Alikes					9.00
9.01	OTHER (SPECIFY)					9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
					1.00	2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)					11.00
	CLINIC		08:00	17:00	08:00	
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00

MCRIF32 - 15.12.167.2

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1320 Component CCN: 14-3989		Period: From 01/01/2019 To 12/31/2019 Worksheet S-8 Date/Time Prepared: 3/31/2020 9:55 am		
		RHC II		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	144 ILLINOIS				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	CHRISMAN		IL 61924	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					4.00
5.00	Community Health Center (Section 330(d), PHS Act)					5.00
6.00	Migrant Health Center (Section 329(d), PHS Act)					6.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)					7.00
8.00	Appalachian Regional Commission					8.00
9.00	Look-Alikes					9.00
9.01	OTHER (SPECIFY)					9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
					1.00	
					2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N				0 10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)					11.00
	CLINIC		08:00	12:00	13:30	
					1.00	
					2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N				0 13.00
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320

Period:

Worksheet S-8

Component CCN: 14-3989

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

3/31/2020 9:55 am

RHC II

Cost

				County				
				4.00				
2.00	City, State, ZIP Code, County			EDGAR				2.00
			Tuesday	Wednesday		Thursday		
			to	from	to	from	to	
			6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)								
11.00	CLINIC	19:30			08:00	12:00		11.00
		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
Facility hours of operations (1)								
11.00	CLINIC	08:00	12:00					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1320 Component CCN: 14-8596		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 3/31/2020 9:55 am	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			721 EAST COURT ST			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			PARIS IL 61944		2.00			
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		17:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N		0		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.							13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			EDGAR				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00		08:00		19:00	
				08:00		19:00		11.00	

Health Financial Systems			PARIS COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1320		Period: From 01/01/2019		Worksheet S-8	
				Component CCN: 14-8596		To 12/31/2019		Date/Time Prepared: 3/31/2020 9:55 am	
				RHC III			Cost		
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	08:00	19:00	08:00	11:30	11.00			

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1320 Component CCN: 14-8607		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 3/31/2020 9:55 am	
				RHC IV		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				1 PHILLIPS LANE		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				PARIS IL 61944		2.00		
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		17:00		08:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N		0		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.								13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				EDGAR				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		08:00		19:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1320 Component CCN: 14-8607		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 3/31/2020 9:55 am	
						RHC IV		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	08:00	19:00	08:00	11:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1320 Component CCN: 14-8606		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 3/31/2020 9:55 am	
				RHC V		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1602 NORTH IL HWY 1			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			MARSHALL IL 62441		2.00			
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		17:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N		0		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.							13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			CLARK				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00		08:00		19:00	
				08:00		19:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN:14-1320 Component CCN:14-8606		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 3/31/2020 9:55 am	
						RHC V		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			08:00	19:00	08:00	11:30	11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 3/31/2020 9:55 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.497082 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	6,094,008		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	25,861,946		6.00
7.00	Medicaid cost (line 1 times line 6)	12,855,508		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)	6,761,500		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)	6,761,500		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,403,841	0	1,403,841 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	697,824	0	697,824 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	697,824	0	697,824 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,052,121		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	291,357		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	448,241		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,603,880		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,948,308		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,646,132		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,407,632		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,140,437	1,140,437	671,664	1,812,101	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,505,759	1,505,759	136,950	1,642,709	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	160,532	123,674	284,206	2,580,269	2,864,475	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	3,285,587	7,128,156	10,413,743	-2,920,574	7,493,169	5.01
5.02	00560	ADMITTING	1,174,932	1,143,502	2,318,434	-1,197	2,317,237	5.02
7.00	00700	OPERATION OF PLANT	595,680	958,557	1,554,237	-1,923	1,552,314	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	139,844	139,844	0	139,844	8.00
9.00	00900	HOUSEKEEPING	517,405	287,483	804,888	-741	804,147	9.00
10.00	01000	DIETARY	527,397	318,627	846,024	-535,026	310,998	10.00
11.00	01100	CAFETERIA	0	0	0	535,026	535,026	11.00
13.00	01300	NURSING ADMINISTRATION	692,157	105,185	797,342	0	797,342	13.00
15.00	01500	PHARMACY	295,790	1,554,316	1,850,106	-1,447,553	402,553	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	487,564	90,102	577,666	0	577,666	16.00
17.00	01700	SOCIAL SERVICE	61,569	5,768	67,337	0	67,337	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,405,461	600,609	3,006,070	-54,625	2,951,445	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,434,493	1,689,785	3,124,278	-1,881,487	1,242,791	50.00
53.00	05300	ANESTHESIOLOGY	1,638,907	489,500	2,128,407	-155,549	1,972,858	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,354	1,024,401	2,508,755	-250,649	2,258,106	54.00
60.00	06000	LABORATORY	774,836	1,432,384	2,207,220	-461,447	1,745,773	60.00
65.00	06500	RESPIRATORY THERAPY	536,049	100,806	636,855	-53,617	583,238	65.00
66.00	06600	PHYSICAL THERAPY	1,253,635	200,160	1,453,795	-2,189	1,451,606	66.00
69.00	06900	ELECTROCARDIOLOGY	184,099	107,911	292,010	57,512	349,522	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,838	2,838	0	2,838	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,260,641	2,260,641	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	693,273	693,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,510,643	1,510,643	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,658,521	3,572,616	11,231,137	0	11,231,137	88.00
88.01	08801	RURAL HEALTH CLINIC II	308,657	175,123	483,780	0	483,780	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	559,219	559,219	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	366,186	366,186	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	41,624	41,624	88.04
90.00	09000	CLINIC	128,879	26,967	155,846	-15,456	140,390	90.00
90.01	04951	CHEMO/PAIN	794,869	485,818	1,280,687	-152,853	1,127,834	90.01
90.02	09002	SENIOR CARE	11,336	536,688	548,024	-26,100	521,924	90.02
90.03	09003	SLEEP LAB	69,176	46,393	115,569	-1,024	114,545	90.03
90.04	09001	ORTHOPEDICS	1,130,723	142,198	1,272,921	363	1,273,284	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	89,462	285,642	375,104	0	375,104	90.05
91.00	09100	EMERGENCY	1,274,388	2,069,483	3,343,871	-77,027	3,266,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,046,941	244,295	1,291,236	-11,792	1,279,444	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		395,512	395,512	-395,512	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,023,399	28,130,539	58,153,938	967,029	59,120,967	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,888	30,278	39,166	0	39,166	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	306,153	69,713	375,866	0	375,866	192.02
192.03	19203	OAKLAND CLINIC	502,003	145,991	647,994	-559,219	88,775	192.03
192.04	19204	EZ CARE CLINIC	936,909	440,768	1,377,677	-366,186	1,011,491	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	206,621	109,912	316,533	-41,624	274,909	192.05
200.00		TOTAL (SUM OF LINES 118 through 199)	31,983,973	28,927,201	60,911,174	0	60,911,174	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet A
Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-115,004	1,697,097	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,642,709	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-204,911	2,659,564	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-489,566	7,003,603	5.01
5.02	00560	ADMITTING	-108	2,317,129	5.02
7.00	00700	OPERATION OF PLANT	-15,026	1,537,288	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	139,844	8.00
9.00	00900	HOUSEKEEPING	0	804,147	9.00
10.00	01000	DIETARY	-13,165	297,833	10.00
11.00	01100	CAFETERIA	-112,023	423,003	11.00
13.00	01300	NURSING ADMINISTRATION	-60	797,282	13.00
15.00	01500	PHARMACY	-1,528	401,025	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,821	572,845	16.00
17.00	01700	SOCIAL SERVICE	0	67,337	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-608,499	2,342,946	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	27	1,242,818	50.00
53.00	05300	ANESTHESIOLOGY	-1,259,721	713,137	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-635,158	1,622,948	54.00
60.00	06000	LABORATORY	-2,892	1,742,881	60.00
65.00	06500	RESPIRATORY THERAPY	0	583,238	65.00
66.00	06600	PHYSICAL THERAPY	-9,288	1,442,318	66.00
69.00	06900	ELECTROCARDIOLOGY	-54,348	295,174	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,838	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,260,641	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	693,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,006	1,505,637	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-121,960	11,109,177	88.00
88.01	08801	RURAL HEALTH CLINIC II	-3,804	479,976	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	559,219	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	366,186	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	41,624	88.04
90.00	09000	CLINIC	-9,030	131,360	90.00
90.01	04951	CHEMO/PAIN	-131,348	996,486	90.01
90.02	09002	SENIOR CARE	-6,372	515,552	90.02
90.03	09003	SLEEP LAB	-26,917	87,628	90.03
90.04	09001	ORTHOPEDICS	-982,228	291,056	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	375,104	90.05
91.00	09100	EMERGENCY	-1,477,683	1,789,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-7,736	1,271,708	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,301,013	52,819,954	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,166	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	192.01
192.02	19201	NAL CLINIC	0	375,866	192.02
192.03	19203	OAKLAND CLINIC	0	88,775	192.03
192.04	19204	EZ CARE CLINIC	0	1,011,491	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	274,909	192.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,301,013	54,610,161	200.00

RECLASSIFICATIONS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
3/31/2020 9:55 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	136,950		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
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	0		0	136,950		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	333,526	201,500		1.00
	0		333,526	201,500		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	42,030	0		1.00
2.00		0.00	0	0		2.00
	0		42,030	0		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	276,152		1.00
	0		0	276,152		
	E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,260,641		1.00
2.00	CLINIC	90.00	0	106		2.00
3.00	SLEEP LAB	90.03	0	16		3.00
4.00	ORTHOPEDICS	90.04	0	363		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	2,261,126		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,510,643		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	52		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	1,510,695		
	I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	12,801	2,681		1.00
	0		12,801	2,681		
	J - IMPLANT EXPENSE					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	693,273		1.00
	0		0	693,273		
	K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	395,512		1.00
	0		0	395,512		
	L - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,580,500		1.00
	0		0	2,580,500		
	M - OAKLAND					
1.00	RURAL HEALTH CLINIC III	88.02	433,229	125,990		1.00
	TOTALS		433,229	125,990		

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	N - EZ CARE				
1.00	RURAL HEALTH CLINIC IV	88.03	249,030	117,156	1.00
	TOTALS		249,030	117,156	
	O - MARSHALL EZ CARE				
1.00	RURAL HEALTH CLINIC V	88.04	27,171	14,453	1.00
	TOTALS		27,171	14,453	
500.00	Grand Total: Increases		1,097,787	8,315,988	500.00

RECLASSIFICATIONS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
3/31/2020 9:55 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	231	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45,439	0		2.00
3.00	ADMITTING	5.02	0	618	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1,923	0		4.00
5.00	PHARMACY	15.00	0	1,000	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	2,585	0		6.00
7.00	OPERATING ROOM	50.00	0	45,967	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	409	0		8.00
9.00	LABORATORY	60.00	0	180	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	11,458	0		10.00
11.00	SENIOR CARE	90.02	0	26,100	0		11.00
12.00	SLEEP LAB	90.03	0	1,040	0		12.00
			0	136,950			
	B - CAFETERIA						
1.00	DIETARY	10.00	333,526	201,500	0		1.00
			333,526	201,500			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	11,079	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	30,951	0	0		2.00
			42,030	0			
	D - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	276,152	12		1.00
			0	276,152			
	E - OXYGEN/PATIENT SUPPLIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	18,535	0		1.00
2.00	ADMITTING	5.02	0	579	0		2.00
3.00	HOUSEKEEPING	9.00	0	741	0		3.00
4.00	PHARMACY	15.00	0	21,960	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	40,615	0		5.00
6.00	OPERATING ROOM	50.00	0	1,142,247	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	149,624	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	242,079	0		8.00
9.00	LABORATORY	60.00	0	461,267	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	9,661	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	963	0		11.00
12.00	CHEMO/PAIN	90.01	0	87,633	0		12.00
13.00	EMERGENCY	91.00	0	74,973	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	10,249	0		14.00
			0	2,261,126			
	F - DRUGS						
1.00	PHARMACY	15.00	0	1,424,593	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	346	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	5,516	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,570	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	1,547	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	1,226	0		6.00
7.00	CLINIC	90.00	0	80	0		7.00
8.00	CHEMO/PAIN	90.01	0	65,220	0		8.00
9.00	EMERGENCY	91.00	0	2,054	0		9.00
10.00	AMBULANCE SERVICES	95.00	0	1,543	0		10.00
			0	1,510,695			
	I - STRESS TEST						
1.00	CLINIC	90.00	12,801	2,681	0		1.00
			12,801	2,681			
	J - IMPLANT EXPENSE						
1.00	OPERATING ROOM	50.00	0	693,273	0		1.00
			0	693,273			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	395,512	9		1.00
			0	395,512			
	L - BENEFITS RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	2,580,500	0		1.00
			0	2,580,500			
	M - OAKLAND						
1.00	OAKLAND CLINIC	192.03	433,229	125,990	0		1.00
	TOTALS		433,229	125,990			

RECLASSIFICATIONS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
3/31/2020 9:55 am

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	N - EZ CARE					
1.00	EZ CARE CLINIC	192.04	249,030	117,156	0	1.00
	TOTALS		249,030	117,156		
	O - MARSHALL EZ CARE					
1.00	MARSHALL EZ CARE CLINIC	192.05	27,171	14,453	0	1.00
	TOTALS		27,171	14,453		
500.00	Grand Total: Decreases		1,097,787	8,315,988		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
3/31/2020 9:55 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	434,175	0	0	0	110,000	1.00	
2.00	Land Improvements	2,324,864	198,766	0	198,766	0	2.00	
3.00	Buildings and Fixtures	29,155,875	11,880,777	0	11,880,777	0	3.00	
4.00	Building Improvements	7,213,975	0	0	0	3,443,102	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	19,459,868	1,597,381	0	1,597,381	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	58,588,757	13,676,924	0	13,676,924	3,553,102	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	58,588,757	13,676,924	0	13,676,924	3,553,102	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	324,175	0					1.00
2.00	Land Improvements	2,523,630	0					
3.00	Buildings and Fixtures	41,036,652	0					
4.00	Building Improvements	3,770,873	0					4.00
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	21,057,249	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	68,712,579	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	68,712,579	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,140,437	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,505,759	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,646,196	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,140,437				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,505,759				2.00
3.00	Total (sum of lines 1-2)	0	2,646,196				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	47,655,330	0	47,655,330	0.693546	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	21,057,249	0	21,057,249	0.306454	0	2.00
3.00	Total (sum of lines 1-2)	68,712,579	0	68,712,579	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,420,945	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,505,759	136,950	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,926,704	136,950	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	276,152	0	0	1,697,097	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,642,709	2.00
3.00	Total (sum of lines 1-2)	0	276,152	0	0	3,339,806	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-115,004	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-3,063	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-245	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,066,181			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-111,930	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-40,999	OTHER ADMINISTRATIVE AND GENERAL	5.01	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	-20,640	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,786	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUITING-OTHER ADMINISTR	A	-15,049	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
34.00	ADVERTISING-EMPLOYEE BENEFITS DEPART	A	-71	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01	ADVERTISING-OTHER ADMINISTRATIVE AND	A	-131,562	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	34.01
34.02	ADVERTISING-ADMITTING	A	-50	ADMITTING	5.02	0	34.02
34.03	ADVERTISING-DIETARY	A	-6	DIETARY	10.00	0	34.03
34.04	ADVERTISING-NURSING ADMINISTRATION	A	-60	NURSING ADMINISTRATION	13.00	0	34.04
34.05	ADVERTISING-RURAL HEALTH CLINIC	A	-94,466	RURAL HEALTH CLINIC	88.00	0	34.05
34.06	ADVERTISING-RURAL HEALTH CLINIC II	A	-3,804	RURAL HEALTH CLINIC II	88.01	0	34.06
34.07	ADVERTISING-CLINIC	A	-30	CLINIC	90.00	0	34.07
34.08	ADVERTISING-CHEMO/PAIN	A	-285	CHEMO/PAIN	90.01	0	34.08
34.09	ADVERTISING-SENIOR CARE	A	-6,383	SENIOR CARE	90.02	0	34.09
34.10	ADVERTISING-ORTHOPEDICS	A	-141	ORTHOPEDICS	90.04	0	34.10
34.11	ADVERTISING-EMERGENCY	A	-270	EMERGENCY	91.00	0	34.11
34.12	ADVERTISING-AMBULANCE SERVICES	A	-6,371	AMBULANCE SERVICES	95.00	0	34.12
35.00	ANESTHESIA	A	-1,134,593	ANESTHESIOLOGY	53.00	0	35.00
36.00	ANESTHESIA BENEFITS	A	-125,122	ANESTHESIOLOGY	53.00	0	36.00
36.01	ANESTHESIA BENEFITS	A	-204,834	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
37.00	OTHER REVENUE-EMPLOYEE BENEFITS DEPA	B	-6	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
37.01	OTHER REVENUE-OTHER ADMINISTRATIVE A	B	-108,441	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	37.01
37.02	OTHER REVENUE-ADMITTING	B	-58	ADMITTING	5.02	0	37.02
37.03	OTHER REVENUE-OPERATION OF PLANT	B	-15,026	OPERATION OF PLANT	7.00	0	37.03
37.04	OTHER REVENUE-DIETARY	B	-13,159	DIETARY	10.00	0	37.04
37.05	OTHER REVENUE-CAFETERIA	B	-93	CAFETERIA	11.00	0	37.05
37.06	OTHER REVENUE-PHARMACY	B	-1,528	PHARMACY	15.00	0	37.06
37.07	OTHER REVENUE-MEDICAL RECORDS & LIBR	B	-35	MEDICAL RECORDS & LIBRARY	16.00	0	37.07
37.08	OTHER REVENUE-ADULTS & PEDIATRICS	B	0	ADULTS & PEDIATRICS	30.00	0	37.08
37.09	OTHER REVENUE-OPERATING ROOM	B	27	OPERATING ROOM	50.00	0	37.09
37.10	OTHER REVENUE-ANESTHESIOLOGY	B	-6	ANESTHESIOLOGY	53.00	0	37.10
37.11	OTHER REVENUE-RADIOLOGY-DIAGNOSTIC	B	-142	RADIOLOGY-DIAGNOSTIC	54.00	0	37.11
37.12	OTHER REVENUE-LABORATORY	B	-2,892	LABORATORY	60.00	0	37.12
37.13	OTHER REVENUE-PHYSICAL THERAPY	B	-9,288	PHYSICAL THERAPY	66.00	0	37.13
37.14	OTHER REVENUE-DRUGS CHARGED TO PATIE	B	15,634	DRUGS CHARGED TO PATIENTS	73.00	0	37.14
37.15	OTHER REVENUE-RURAL HEALTH CLINIC	B	-27,494	RURAL HEALTH CLINIC	88.00	0	37.15
37.16	OTHER REVENUE-CHEMO/PAIN	B	-36,266	CHEMO/PAIN	90.01	0	37.16
37.17	OTHER REVENUE-SENIOR CARE	B	11	SENIOR CARE	90.02	0	37.17
37.18	OTHER REVENUE-ORTHOPEDICS	B	-750	ORTHOPEDICS	90.04	0	37.18
37.19	OTHER REVENUE-AMBULANCE SERVICES	B	-1,365	AMBULANCE SERVICES	95.00	0	37.19
38.00	LOBBYING DUES	A	-14,191	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,301,013				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.

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		07/31/2020 0:00 am	
			Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-2

Date/Time Prepared:
3/31/2020 9:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	176,016	176,016	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	608,499	608,499	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	635,016	635,016	0	0	0	3.00
4.00	60.00	LABORATORY	70,000	0	70,000	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	66,348	54,348	12,000	0	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	2,838	2,838	0	0	0	6.00
7.00	90.00	CLINIC	9,000	9,000	0	0	0	7.00
8.00	90.01	CHEMO/PAIN	124,797	94,797	30,000	0	0	8.00
9.00	90.02	SENIOR CARE	36,000	0	36,000	0	0	9.00
10.00	90.03	SLEEP LAB	32,417	26,917	5,500	0	0	10.00
11.00	90.04	ORTHOPEDICS	981,337	981,337	0	0	0	11.00
12.00	91.00	EMERGENCY	1,865,743	1,477,413	388,330	0	0	12.00
200.00			4,608,011	4,066,181	541,830		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	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.01	CHEMO/PAIN	0	0	0	0	0	8.00
9.00	90.02	SENIOR CARE	0	0	0	0	0	9.00
10.00	90.03	SLEEP LAB	0	0	0	0	0	10.00
11.00	90.04	ORTHOPEDICS	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
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	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	176,016		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	608,499		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	635,016		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	54,348		5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	2,838		6.00
7.00	90.00	CLINIC	0	0	0	9,000		7.00
8.00	90.01	CHEMO/PAIN	0	0	0	94,797		8.00
9.00	90.02	SENIOR CARE	0	0	0	0		9.00
10.00	90.03	SLEEP LAB	0	0	0	26,917		10.00
11.00	90.04	ORTHOPEDICS	0	0	0	981,337		11.00
12.00	91.00	EMERGENCY	0	0	0	1,477,413		12.00
200.00			0	0	0	4,066,181		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,697,097	1,697,097			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,642,709	1,642,709			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,659,564	12,890	12,477	2,684,931	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	7,003,603	284,124	275,019	424,913	7,987,659
5.02	00560	ADMITTING	2,317,129	45,748	44,282	151,948	2,559,107
7.00	00700	OPERATION OF PLANT	1,537,288	164,929	159,644	77,036	1,938,897
8.00	00800	LAUNDRY & LINEN SERVICE	139,844	13,502	13,069	0	166,415
9.00	00900	HOUSEKEEPING	804,147	9,497	9,193	66,913	889,750
10.00	01000	DIETARY	297,833	42,661	41,294	25,072	406,860
11.00	01100	CAFETERIA	423,003	19,412	18,790	43,133	504,338
13.00	01300	NURSING ADMINISTRATION	797,282	19,189	18,574	89,513	924,558
15.00	01500	PHARMACY	401,025	12,111	11,723	38,253	463,112
16.00	01600	MEDICAL RECORDS & LIBRARY	572,845	31,022	30,028	63,054	696,949
17.00	01700	SOCIAL SERVICE	67,337	2,169	2,100	7,962	79,568
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,342,946	194,756	188,514	309,653	3,035,869
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,242,818	195,660	189,389	185,516	1,813,383
53.00	05300	ANESTHESIOLOGY	713,137	1,655	1,602	65,220	781,614
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,622,948	102,412	99,129	191,964	2,016,453
60.00	06000	LABORATORY	1,742,881	42,675	41,307	100,206	1,927,069
65.00	06500	RESPIRATORY THERAPY	583,238	5,298	5,128	65,322	658,986
66.00	06600	PHYSICAL THERAPY	1,442,318	325,478	315,045	162,126	2,244,967
69.00	06900	ELECTROCARDIOLOGY	295,174	7,286	7,053	30,900	340,413
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,260,641	0	0	0	2,260,641
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	693,273	0	0	0	693,273
73.00	07300	DRUGS CHARGED TO PATIENTS	1,505,637	0	0	0	1,505,637
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,109,177	0	0	0	11,109,177
88.01	08801	RURAL HEALTH CLINIC II	479,976	0	0	0	479,976
88.02	08802	RURAL HEALTH CLINIC III	559,219	0	0	0	559,219
88.03	08803	RURAL HEALTH CLINIC IV	366,186	0	0	0	366,186
88.04	08804	RURAL HEALTH CLINIC V	41,624	0	0	0	41,624
90.00	09000	CLINIC	131,360	8,552	8,278	15,012	163,202
90.01	04951	CHEMO/PAIN	996,486	21,470	20,782	102,796	1,141,534
90.02	09002	SENIOR CARE	515,552	0	0	1,466	517,018
90.03	09003	SLEEP LAB	87,628	1,808	1,750	8,946	100,132
90.04	09001	ORTHOPEDICS	291,056	25,627	24,806	146,231	487,720
90.05	09004	BEHAVIORAL HEALTH CLINIC	375,104	5,951	5,761	11,570	398,386
91.00	09100	EMERGENCY	1,789,161	71,667	69,370	164,810	2,095,008
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,271,708	0	0	135,396	1,407,104
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,819,954	1,667,549	1,614,107	2,684,931	52,761,804
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,166	29,548	28,602	0	97,316
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0
192.02	19201	NAL CLINIC	375,866	0	0	0	375,866
192.03	19203	OAKLAND CLINIC	88,775	0	0	0	88,775
192.04	19204	EZ CARE CLINIC	1,011,491	0	0	0	1,011,491
192.05	19205	MARSHALL EZ CARE CLINIC	274,909	0	0	0	274,909
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		TOTAL (sum lines 118 through 201)	54,610,161	1,697,097	1,642,709	2,684,931	54,610,161

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	7,987,659					5.01
5.02	00560	ADMITTING	438,442	2,997,549				5.02
7.00	00700	OPERATION OF PLANT	332,183	0	2,271,080			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,511	0	25,781	220,707		8.00
9.00	00900	HOUSEKEEPING	152,437	0	18,134	0	1,060,321	9.00
10.00	01000	DIETARY	69,706	0	81,458	0	38,781	10.00
11.00	01100	CAFETERIA	86,406	0	37,065	0	17,646	11.00
13.00	01300	NURSING ADMINISTRATION	158,401	0	36,640	0	17,444	13.00
15.00	01500	PHARMACY	79,343	0	23,126	0	11,010	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	119,405	0	59,235	0	28,201	16.00
17.00	01700	SOCIAL SERVICE	13,632	0	4,142	0	1,972	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	520,123	440,608	371,871	220,707	177,042	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	310,680	263,182	373,597	0	177,864	50.00
53.00	05300	ANESTHESIOLOGY	133,911	0	3,160	0	1,504	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,471	292,674	195,547	0	93,097	54.00
60.00	06000	LABORATORY	330,157	279,820	81,485	0	38,794	60.00
65.00	06500	RESPIRATORY THERAPY	112,901	95,644	10,116	0	4,816	65.00
66.00	06600	PHYSICAL THERAPY	384,621	317,388	621,473	0	295,876	66.00
69.00	06900	ELECTROCARDIOLOGY	58,322	49,411	13,913	0	6,624	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	387,307	328,425	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	118,776	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	257,955	218,738	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,903,304	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	82,232	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	95,809	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	62,737	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	7,131	0	0	0	0	88.04
90.00	09000	CLINIC	27,961	23,688	16,329	0	7,774	90.00
90.01	04951	CHEMO/PAIN	195,574	165,694	40,995	0	19,517	90.01
90.02	09002	SENIOR CARE	88,579	75,110	0	0	0	90.02
90.03	09003	SLEEP LAB	17,155	14,534	3,452	0	1,643	90.03
90.04	09001	ORTHOPEDICS	83,559	70,646	48,933	0	23,296	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	68,254	57,861	11,364	0	5,410	90.05
91.00	09100	EMERGENCY	358,929	304,126	136,843	0	65,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	241,073	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,670,987	2,997,549	2,214,659	220,707	1,033,460	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,673	0	56,421	0	26,861	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	64,396	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	15,209	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	173,295	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	47,099	0	0	0	0	192.05
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)	7,987,659	2,997,549	2,271,080	220,707	1,060,321	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	596,805					10.00
11.00	01100	CAFETERIA	0	645,455				11.00
13.00	01300	NURSING ADMINISTRATION	0	30,469	1,167,512			13.00
15.00	01500	PHARMACY	0	13,021	0	589,612		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,463	0	0	925,253	16.00
17.00	01700	SOCIAL SERVICE	0	2,710	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	596,805	105,407	467,164	0	34,167	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	63,148	229,458	0	111,921	50.00
53.00	05300	ANESTHESIOLOGY	0	22,200	0	0	16,504	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,343	0	0	236,412	54.00
60.00	06000	LABORATORY	0	34,109	0	0	164,049	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,235	0	0	7,459	65.00
66.00	06600	PHYSICAL THERAPY	0	55,186	0	0	108,439	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,518	0	0	17,388	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	178	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	42,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	11,408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	589,612	81,153	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	5,210	0	0	1,404	90.00
90.01	04951	CHEMO/PAIN	0	34,991	105,587	0	9,883	90.01
90.02	09002	SENIOR CARE	0	499	1,874	0	7,058	90.02
90.03	09003	SLEEP LAB	0	3,045	0	0	3,177	90.03
90.04	09001	ORTHOPEDICS	0	49,776	0	0	2,765	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	3,938	0	0	2,571	90.05
91.00	09100	EMERGENCY	0	56,100	190,309	0	67,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	46,087	173,120	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	596,805	645,455	1,167,512	589,612	925,253	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0	192.05
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)	596,805	645,455	1,167,512	589,612	925,253	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	ADMITTING					5.02
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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	102,024				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	102,024	6,071,787	0	6,071,787	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,343,233	0	3,343,233	50.00
53.00	05300	ANESTHESIOLOGY	0	958,893	0	958,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,244,997	0	3,244,997	54.00
60.00	06000	LABORATORY	0	2,855,483	0	2,855,483	60.00
65.00	06500	RESPIRATORY THERAPY	0	912,157	0	912,157	65.00
66.00	06600	PHYSICAL THERAPY	0	4,027,950	0	4,027,950	66.00
69.00	06900	ELECTROCARDIOLOGY	0	496,589	0	496,589	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	178	0	178	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,018,398	0	3,018,398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	823,457	0	823,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,653,095	0	2,653,095	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	13,012,481	0	13,012,481	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	562,208	0	562,208	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	655,028	0	655,028	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	428,923	0	428,923	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	48,755	0	48,755	88.04
90.00	09000	CLINIC	0	245,568	0	245,568	90.00
90.01	04951	CHEMO/PAIN	0	1,713,775	0	1,713,775	90.01
90.02	09002	SENIOR CARE	0	690,138	0	690,138	90.02
90.03	09003	SLEEP LAB	0	143,138	0	143,138	90.03
90.04	09001	ORTHOPEDICS	0	766,695	0	766,695	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	547,784	0	547,784	90.05
91.00	09100	EMERGENCY	0	3,273,756	0	3,273,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,867,384	0	1,867,384	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,024	52,361,850	0	52,361,850	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	197,271	0	197,271	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	440,262	0	440,262	192.02
192.03	19203	OAKLAND CLINIC	0	103,984	0	103,984	192.03
192.04	19204	EZ CARE CLINIC	0	1,184,786	0	1,184,786	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	322,008	0	322,008	192.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	102,024	54,610,161	0	54,610,161	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,890	12,477	25,367	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	284,124	275,019	559,143	5.01
5.02	00560	ADMITTING	0	45,748	44,282	90,030	5.02
7.00	00700	OPERATION OF PLANT	0	164,929	159,644	324,573	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,502	13,069	26,571	8.00
9.00	00900	HOUSEKEEPING	0	9,497	9,193	18,690	9.00
10.00	01000	DIETARY	0	42,661	41,294	83,955	10.00
11.00	01100	CAFETERIA	0	19,412	18,790	38,202	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,189	18,574	37,763	13.00
15.00	01500	PHARMACY	0	12,111	11,723	23,834	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,022	30,028	61,050	16.00
17.00	01700	SOCIAL SERVICE	0	2,169	2,100	4,269	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	194,756	188,514	383,270	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	195,660	189,389	385,049	50.00
53.00	05300	ANESTHESIOLOGY	0	1,655	1,602	3,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	102,412	99,129	201,541	54.00
60.00	06000	LABORATORY	0	42,675	41,307	83,982	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,298	5,128	10,426	65.00
66.00	06600	PHYSICAL THERAPY	0	325,478	315,045	640,523	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,286	7,053	14,339	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
90.00	09000	CLINIC	0	8,552	8,278	16,830	90.00
90.01	04951	CHEMO/PAIN	0	21,470	20,782	42,252	90.01
90.02	09002	SENIOR CARE	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	1,808	1,750	3,558	90.03
90.04	09001	ORTHOPEDICS	0	25,627	24,806	50,433	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	5,951	5,761	11,712	90.05
91.00	09100	EMERGENCY	0	71,667	69,370	141,037	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,667,549	1,614,107	3,281,656	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,548	28,602	58,150	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	192.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,697,097	1,642,709	3,339,806	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	563,155					5.01
5.02	00560	ADMITTING	30,911	122,377				5.02
7.00	00700	OPERATION OF PLANT	23,420	0	348,721			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,010	0	3,959	32,540		8.00
9.00	00900	HOUSEKEEPING	10,747	0	2,784	0	32,853	9.00
10.00	01000	DIETARY	4,914	0	12,508	0	1,202	10.00
11.00	01100	CAFETERIA	6,092	0	5,691	0	547	11.00
13.00	01300	NURSING ADMINISTRATION	11,168	0	5,626	0	540	13.00
15.00	01500	PHARMACY	5,594	0	3,551	0	341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,418	0	9,095	0	874	16.00
17.00	01700	SOCIAL SERVICE	961	0	636	0	61	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,670	17,980	57,100	32,540	5,485	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,904	10,746	57,365	0	5,511	50.00
53.00	05300	ANESTHESIOLOGY	9,441	0	485	0	47	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,357	11,950	30,026	0	2,885	54.00
60.00	06000	LABORATORY	23,277	11,425	12,512	0	1,202	60.00
65.00	06500	RESPIRATORY THERAPY	7,960	3,905	1,553	0	149	65.00
66.00	06600	PHYSICAL THERAPY	27,117	12,959	95,428	0	9,166	66.00
69.00	06900	ELECTROCARDIOLOGY	4,112	2,017	2,136	0	205	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,306	13,409	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,374	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,187	8,931	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	134,191	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,798	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,755	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,423	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	503	0	0	0	0	88.04
90.00	09000	CLINIC	1,971	967	2,507	0	241	90.00
90.01	04951	CHEMO/PAIN	13,789	6,765	6,295	0	605	90.01
90.02	09002	SENIOR CARE	6,245	3,067	0	0	0	90.02
90.03	09003	SLEEP LAB	1,209	593	530	0	51	90.03
90.04	09001	ORTHOPEDICS	5,891	2,884	7,514	0	722	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	4,812	2,362	1,745	0	168	90.05
91.00	09100	EMERGENCY	25,306	12,417	21,012	0	2,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	16,996	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	540,829	122,377	340,058	32,540	32,021	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,175	0	8,663	0	832	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	4,540	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	1,072	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	12,218	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	3,321	0	0	0	0	192.05
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)	563,155	122,377	348,721	32,540	32,853	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	102,816					10.00
11.00	01100	CAFETERIA	0	50,940				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,405	58,348			13.00
15.00	01500	PHARMACY	0	1,028	0	34,709		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,694	0	0	81,727	16.00
17.00	01700	SOCIAL SERVICE	0	214	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	102,816	8,321	23,347	0	3,019	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,983	11,467	0	9,889	50.00
53.00	05300	ANESTHESIOLOGY	0	1,752	0	0	1,458	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,157	0	0	20,863	54.00
60.00	06000	LABORATORY	0	2,692	0	0	14,495	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,755	0	0	659	65.00
66.00	06600	PHYSICAL THERAPY	0	4,355	0	0	9,581	66.00
69.00	06900	ELECTROCARDIOLOGY	0	830	0	0	1,536	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	16	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,709	7,171	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	411	0	0	124	90.00
90.01	04951	CHEMO/PAIN	0	2,761	5,277	0	873	90.01
90.02	09002	SENIOR CARE	0	39	94	0	624	90.02
90.03	09003	SLEEP LAB	0	240	0	0	281	90.03
90.04	09001	ORTHOPEDICS	0	3,928	0	0	244	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	311	0	0	227	90.05
91.00	09100	EMERGENCY	0	4,427	9,511	0	5,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	3,637	8,652	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,816	50,940	58,348	34,709	81,727	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0	192.05
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)	102,816	50,940	58,348	34,709	81,727	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL				5.01
5.02	00560	ADMITTING				5.02
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	6,216			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,216	679,690	0	679,690
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	508,667	0	508,667
53.00	05300	ANESTHESIOLOGY	0	17,056	0	17,056
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	298,593	0	298,593
60.00	06000	LABORATORY	0	150,532	0	150,532
65.00	06500	RESPIRATORY THERAPY	0	27,024	0	27,024
66.00	06600	PHYSICAL THERAPY	0	800,661	0	800,661
69.00	06900	ELECTROCARDIOLOGY	0	25,467	0	25,467
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16	0	16
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,428	0	44,428
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,382	0	9,382
73.00	07300	DRUGS CHARGED TO PATIENTS	0	68,998	0	68,998
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	134,191	0	134,191
88.01	08801	RURAL HEALTH CLINIC II	0	5,798	0	5,798
88.02	08802	RURAL HEALTH CLINIC III	0	6,755	0	6,755
88.03	08803	RURAL HEALTH CLINIC IV	0	4,423	0	4,423
88.04	08804	RURAL HEALTH CLINIC V	0	503	0	503
90.00	09000	CLINIC	0	23,193	0	23,193
90.01	04951	CHEMO/PAIN	0	79,588	0	79,588
90.02	09002	SENIOR CARE	0	10,083	0	10,083
90.03	09003	SLEEP LAB	0	6,547	0	6,547
90.04	09001	ORTHOPEDICS	0	72,998	0	72,998
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	21,446	0	21,446
91.00	09100	EMERGENCY	0	223,232	0	223,232
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	30,564	0	30,564
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,216	3,249,835	0	3,249,835
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	68,820	0	68,820
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0
192.02	19201	NAL CLINIC	0	4,540	0	4,540
192.03	19203	OAKLAND CLINIC	0	1,072	0	1,072
192.04	19204	EZ CARE CLINIC	0	12,218	0	12,218
192.05	19205	MARSHALL EZ CARE CLINIC	0	3,321	0	3,321
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	6,216	3,339,806	0	3,339,806

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A.01	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	122,048				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		122,048			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	927	927	20,761,096		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	20,433	20,433	3,285,587	-7,987,659	5.01
5.02	00560	ADMITTING	3,290	3,290	1,174,932	0	5.02
7.00	00700	OPERATION OF PLANT	11,861	11,861	595,680	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	8.00
9.00	00900	HOUSEKEEPING	683	683	517,405	0	9.00
10.00	01000	DIETARY	3,068	3,068	193,871	0	10.00
11.00	01100	CAFETERIA	1,396	1,396	333,526	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,380	1,380	692,157	0	13.00
15.00	01500	PHARMACY	871	871	295,790	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	487,564	0	16.00
17.00	01700	SOCIAL SERVICE	156	156	61,569	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,006	14,006	2,394,382	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,071	14,071	1,434,493	0	50.00
53.00	05300	ANESTHESIOLOGY	119	119	504,314	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,365	7,365	1,484,354	0	54.00
60.00	06000	LABORATORY	3,069	3,069	774,836	0	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	505,098	0	65.00
66.00	06600	PHYSICAL THERAPY	23,407	23,407	1,253,635	0	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	238,930	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
90.00	09000	CLINIC	615	615	116,078	0	90.00
90.01	04951	CHEMO/PAIN	1,544	1,544	794,869	0	90.01
90.02	09002	SENIOR CARE	0	0	11,336	0	90.02
90.03	09003	SLEEP LAB	130	130	69,176	0	90.03
90.04	09001	ORTHOPEDICS	1,843	1,843	1,130,723	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	428	428	89,462	0	90.05
91.00	09100	EMERGENCY	5,154	5,154	1,274,388	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	1,046,941	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	119,923	119,923	20,761,096	-7,987,659	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,125	2,125	0	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	192.05
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)	1,697,097	1,642,709	2,684,931	7,987,659	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.905160	13.459532	0.129325	0.171326	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			25,367	563,155	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001222	0.012079	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: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		ADMITTING (ACCU. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		5.02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	ADMITTING	24,211,449				5.02
7.00	00700	OPERATION OF PLANT	0	85,537			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100		8.00
9.00	00900	HOUSEKEEPING	0	683	0	83,883	9.00
10.00	01000	DIETARY	0	3,068	0	3,068	100 10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,380	0	1,380	0 13.00
15.00	01500	PHARMACY	0	871	0	871	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	0 16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,558,814	14,006	100	14,006	100 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,125,741	14,071	0	14,071	0 50.00
53.00	05300	ANESTHESIOLOGY	0	119	0	119	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,363,956	7,365	0	7,365	0 54.00
60.00	06000	LABORATORY	2,260,131	3,069	0	3,069	0 60.00
65.00	06500	RESPIRATORY THERAPY	772,522	381	0	381	0 65.00
66.00	06600	PHYSICAL THERAPY	2,563,571	23,407	0	23,407	0 66.00
69.00	06900	ELECTROCARDIOLOGY	399,095	524	0	524	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,652,715	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,767	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0 88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0 88.04
90.00	09000	CLINIC	191,333	615	0	615	0 90.00
90.01	04951	CHEMO/PAIN	1,338,327	1,544	0	1,544	0 90.01
90.02	09002	SENIOR CARE	606,671	0	0	0	0 90.02
90.03	09003	SLEEP LAB	117,395	130	0	130	0 90.03
90.04	09001	ORTHOPEDICS	570,616	1,843	0	1,843	0 90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	467,346	428	0	428	0 90.05
91.00	09100	EMERGENCY	2,456,449	5,154	0	5,154	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,211,449	83,412	100	81,758	100 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,125	0	2,125	0 192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 192.01
192.02	19201	NAL CLINIC	0	0	0	0	0 192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0 192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0 192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0 192.05
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)	2,997,549	2,271,080	220,707	1,060,321	596,805 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.123807	26.550849	2,207.070000	12.640475	5,968.050000 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	122,377	348,721	32,540	32,853	102,816 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005055	4.076844	325.400000	0.391653	1,028.160000 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: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATIO N (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PAT DAYS)	
			11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	14,662,376					11.00
13.00	01300	NURSING ADMINISTRATION	692,157	7,060,506				13.00
15.00	01500	PHARMACY	295,790	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	487,564	0	0	90,136,031		16.00
17.00	01700	SOCIAL SERVICE	61,569	0	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,394,382	2,825,166	0	3,328,524	100	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,434,493	1,387,642	0	10,903,133	0	50.00
53.00	05300	ANESTHESIOLOGY	504,314	0	0	1,607,798	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,354	0	0	23,030,371	0	54.00
60.00	06000	LABORATORY	774,836	0	0	15,981,404	0	60.00
65.00	06500	RESPIRATORY THERAPY	505,098	0	0	726,674	0	65.00
66.00	06600	PHYSICAL THERAPY	1,253,635	0	0	10,563,918	0	66.00
69.00	06900	ELECTROCARDIOLOGY	238,930	0	0	1,693,884	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	17,356	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,094,032	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,111,310	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	7,905,760	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	118,359	0	0	136,741	0	90.00
90.01	04951	CHEMO/PAIN	794,869	638,534	0	962,779	0	90.01
90.02	09002	SENIOR CARE	11,336	11,336	0	687,595	0	90.02
90.03	09003	SLEEP LAB	69,176	0	0	309,513	0	90.03
90.04	09001	ORTHOPEDICS	1,130,723	0	0	269,345	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	89,462	0	0	250,462	0	90.05
91.00	09100	EMERGENCY	1,274,388	1,150,889	0	6,555,432	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,046,941	1,046,939	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,662,376	7,060,506	100	90,136,031	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
192.03	19203	OAKLAND CLINIC	0	0	0	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	0	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	0	0	0	192.05
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)	645,455	1,167,512	589,612	925,253	102,024	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.044021	0.165358	5,896.120000	0.010265	1,020.240000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	50,940	58,348	34,709	81,727	6,216	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003474	0.008264	347.090000	0.000907	62.160000	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: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/31/2020 9:55 am

		Title XVIII		Hospital		Cost
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	6,071,787		6,071,787	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,343,233		3,343,233	0	0 50.00
53.00	05300 ANESTHESIOLOGY	958,893		958,893	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,244,997		3,244,997	0	0 54.00
60.00	06000 LABORATORY	2,855,483		2,855,483	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	912,157	0	912,157	0	0 65.00
66.00	06600 PHYSICAL THERAPY	4,027,950	0	4,027,950	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	496,589		496,589	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	178		178	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,018,398		3,018,398	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	823,457		823,457	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,653,095		2,653,095	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	13,012,481		13,012,481	0	0 88.00
88.01	08801 RURAL HEALTH CLINIC II	562,208		562,208	0	0 88.01
88.02	08802 RURAL HEALTH CLINIC III	655,028		655,028	0	0 88.02
88.03	08803 RURAL HEALTH CLINIC IV	428,923		428,923	0	0 88.03
88.04	08804 RURAL HEALTH CLINIC V	48,755		48,755	0	0 88.04
90.00	09000 CLINIC	245,568		245,568	0	0 90.00
90.01	04951 CHEMO/PAIN	1,713,775		1,713,775	0	0 90.01
90.02	09002 SENIOR CARE	690,138		690,138	0	0 90.02
90.03	09003 SLEEP LAB	143,138		143,138	0	0 90.03
90.04	09001 ORTHOPEDICS	766,695		766,695	0	0 90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	547,784		547,784	0	0 90.05
91.00	09100 EMERGENCY	3,273,756		3,273,756	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,241,126		1,241,126	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1,867,384		1,867,384	0	0 95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	53,602,976	0	53,602,976	0	0 200.00
201.00	Less Observation Beds	1,241,126		1,241,126		0 201.00
202.00	Total (see instructions)	52,361,850	0	52,361,850	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/31/2020 9:55 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,666,725		2,666,725		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,252,390	9,650,743	10,903,133	0.306630	0.000000
53.00	05300	ANESTHESIOLOGY	244,877	1,363,026	1,607,903	0.596362	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	795,856	22,234,515	23,030,371	0.140901	0.000000
60.00	06000	LABORATORY	1,101,091	14,880,313	15,981,404	0.178675	0.000000
65.00	06500	RESPIRATORY THERAPY	343,726	382,948	726,674	1.255249	0.000000
66.00	06600	PHYSICAL THERAPY	951,131	9,612,787	10,563,918	0.381293	0.000000
69.00	06900	ELECTROCARDIOLOGY	31,103	1,662,781	1,693,884	0.293166	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,356	17,356	0.010256	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	824,435	3,269,647	4,094,082	0.737259	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	572,553	538,757	1,111,310	0.740979	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,544,885	6,360,875	7,905,760	0.335590	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	12,333,634	12,333,634		
88.01	08801	RURAL HEALTH CLINIC II	0	479,828	479,828		
88.02	08802	RURAL HEALTH CLINIC III	0	363,954	363,954		
88.03	08803	RURAL HEALTH CLINIC IV	0	532,596	532,596		
88.04	08804	RURAL HEALTH CLINIC V	0	48,880	48,880		
90.00	09000	CLINIC	0	136,741	136,741	1.795862	0.000000
90.01	04951	CHEMO/PAIN	794	961,985	962,779	1.780029	0.000000
90.02	09002	SENIOR CARE	0	687,595	687,595	1.003698	0.000000
90.03	09003	SLEEP LAB	925	308,588	309,513	0.462462	0.000000
90.04	09001	ORTHOPEDICS	0	269,295	269,295	2.847045	0.000000
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	250,462	250,462	2.187094	0.000000
91.00	09100	EMERGENCY	7,774	6,547,553	6,555,327	0.499404	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,570	656,229	661,799	1.875382	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,443,533	1,443,533	1.293621	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	10,343,835	94,994,621	105,338,456		
201.00		Less Observation Beds					
202.00		Total (see instructions)	10,343,835	94,994,621	105,338,456		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/31/2020 9:55 am

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
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
90.00	09000	CLINIC	0.000000			90.00
90.01	04951	CHEMO/PAIN	0.000000			90.01
90.02	09002	SENIOR CARE	0.000000			90.02
90.03	09003	SLEEP LAB	0.000000			90.03
90.04	09001	ORTHOPEDICS	0.000000			90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/31/2020 9:55 am

			Title XIX		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	6,071,787		6,071,787	0	6,071,787	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,343,233		3,343,233	0	3,343,233	50.00
53.00	05300	ANESTHESIOLOGY	958,893		958,893	0	958,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,244,997		3,244,997	0	3,244,997	54.00
60.00	06000	LABORATORY	2,855,483		2,855,483	0	2,855,483	60.00
65.00	06500	RESPIRATORY THERAPY	912,157	0	912,157	0	912,157	65.00
66.00	06600	PHYSICAL THERAPY	4,027,950	0	4,027,950	0	4,027,950	66.00
69.00	06900	ELECTROCARDIOLOGY	496,589		496,589	0	496,589	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	178		178	0	178	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,018,398		3,018,398	0	3,018,398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	823,457		823,457	0	823,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,653,095		2,653,095	0	2,653,095	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	13,012,481		13,012,481	0	13,012,481	88.00
88.01	08801	RURAL HEALTH CLINIC II	562,208		562,208	0	562,208	88.01
88.02	08802	RURAL HEALTH CLINIC III	655,028		655,028	0	655,028	88.02
88.03	08803	RURAL HEALTH CLINIC IV	428,923		428,923	0	428,923	88.03
88.04	08804	RURAL HEALTH CLINIC V	48,755		48,755	0	48,755	88.04
90.00	09000	CLINIC	245,568		245,568	0	245,568	90.00
90.01	04951	CHEMO/PAIN	1,713,775		1,713,775	0	1,713,775	90.01
90.02	09002	SENIOR CARE	690,138		690,138	0	690,138	90.02
90.03	09003	SLEEP LAB	143,138		143,138	0	143,138	90.03
90.04	09001	ORTHOPEDICS	766,695		766,695	0	766,695	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	547,784		547,784	0	547,784	90.05
91.00	09100	EMERGENCY	3,273,756		3,273,756	0	3,273,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,241,126		1,241,126	0	1,241,126	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,867,384		1,867,384	0	1,867,384	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	53,602,976	0	53,602,976	0	53,602,976	200.00
201.00		Less Observation Beds	1,241,126		1,241,126		1,241,126	201.00
202.00		Total (see instructions)	52,361,850	0	52,361,850	0	52,361,850	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/31/2020 9:55 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,666,725		2,666,725		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,252,390	9,650,743	10,903,133	0.306630	0.000000
53.00	05300	ANESTHESIOLOGY	244,877	1,363,026	1,607,903	0.596362	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	795,856	22,234,515	23,030,371	0.140901	0.000000
60.00	06000	LABORATORY	1,101,091	14,880,313	15,981,404	0.178675	0.000000
65.00	06500	RESPIRATORY THERAPY	343,726	382,948	726,674	1.255249	0.000000
66.00	06600	PHYSICAL THERAPY	951,131	9,612,787	10,563,918	0.381293	0.000000
69.00	06900	ELECTROCARDIOLOGY	31,103	1,662,781	1,693,884	0.293166	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17,356	17,356	0.010256	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	824,435	3,269,647	4,094,082	0.737259	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	572,553	538,757	1,111,310	0.740979	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,544,885	6,360,875	7,905,760	0.335590	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	12,333,634	12,333,634	1.055040	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	479,828	479,828	1.171687	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	363,954	363,954	1.799755	0.000000
88.03	08803	RURAL HEALTH CLINIC IV	0	532,596	532,596	0.805344	0.000000
88.04	08804	RURAL HEALTH CLINIC V	0	48,880	48,880	0.997443	0.000000
90.00	09000	CLINIC	0	136,741	136,741	1.795862	0.000000
90.01	04951	CHEMO/PAIN	794	961,985	962,779	1.780029	0.000000
90.02	09002	SENIOR CARE	0	687,595	687,595	1.003698	0.000000
90.03	09003	SLEEP LAB	925	308,588	309,513	0.462462	0.000000
90.04	09001	ORTHOPEDICS	0	269,295	269,295	2.847045	0.000000
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	250,462	250,462	2.187094	0.000000
91.00	09100	EMERGENCY	7,774	6,547,553	6,555,327	0.499404	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,570	656,229	661,799	1.875382	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,443,533	1,443,533	1.293621	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	10,343,835	94,994,621	105,338,456		
201.00		Less Observation Beds					
202.00		Total (see instructions)	10,343,835	94,994,621	105,338,456		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	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
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000			88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000			88.04
90.00	09000	CLINIC	0.000000			90.00
90.01	04951	CHEMO/PAIN	0.000000			90.01
90.02	09002	SENIOR CARE	0.000000			90.02
90.03	09003	SLEEP LAB	0.000000			90.03
90.04	09001	ORTHOPEDICS	0.000000			90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
3/31/2020 9:55 am

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)	Hospital 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	508,667	10,903,133	0.046653	496,477	23,162	50.00
53.00	05300 ANESTHESIOLOGY	17,056	1,607,903	0.010608	99,489	1,055	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	298,593	23,030,371	0.012965	433,489	5,620	54.00
60.00	06000 LABORATORY	150,532	15,981,404	0.009419	538,150	5,069	60.00
65.00	06500 RESPIRATORY THERAPY	27,024	726,674	0.037189	189,240	7,038	65.00
66.00	06600 PHYSICAL THERAPY	800,661	10,563,918	0.075792	233,615	17,706	66.00
69.00	06900 ELECTROCARDIOLOGY	25,467	1,693,884	0.015035	16,443	247	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	16	17,356	0.000922	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44,428	4,094,082	0.010852	342,769	3,720	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,382	1,111,310	0.008442	268,421	2,266	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	68,998	7,905,760	0.008728	644,892	5,629	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	134,191	12,333,634	0.010880	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	5,798	479,828	0.012083	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	6,755	363,954	0.018560	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	4,423	532,596	0.008305	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	503	48,880	0.010291	0	0	88.04
90.00	09000 CLINIC	23,193	136,741	0.169613	0	0	90.00
90.01	04951 CHEMO/PAIN	79,588	962,779	0.082665	0	0	90.01
90.02	09002 SENIOR CARE	10,083	687,595	0.014664	0	0	90.02
90.03	09003 SLEEP LAB	6,547	309,513	0.021153	924	20	90.03
90.04	09001 ORTHOPEDICS	72,998	269,295	0.271071	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	21,446	250,462	0.085626	0	0	90.05
91.00	09100 EMERGENCY	223,232	6,555,327	0.034054	1,179	40	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	138,934	661,799	0.209934	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	2,678,515	101,228,198		3,265,088	71,572	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description			Title XVIII		Hospital		Cost	
			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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	90.05
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
3/31/2020 9:55 am

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	10,903,133	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,607,903	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,030,371	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	15,981,404	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	726,674	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,563,918	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,693,884	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	17,356	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,094,082	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,111,310	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,905,760	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	12,333,634	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	479,828	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	363,954	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	532,596	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	48,880	0.000000	88.04
90.00	09000	CLINIC	0	0	0	136,741	0.000000	90.00
90.01	04951	CHEMO/PAIN	0	0	0	962,779	0.000000	90.01
90.02	09002	SENIOR CARE	0	0	0	687,595	0.000000	90.02
90.03	09003	SLEEP LAB	0	0	0	309,513	0.000000	90.03
90.04	09001	ORTHOPEDICS	0	0	0	269,295	0.000000	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	250,462	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	6,555,327	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	661,799	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	101,228,198		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
3/31/2020 9:55 am

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	496,477	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	99,489	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	433,489	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	538,150	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	189,240	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	233,615	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,443	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	342,769	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	268,421	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	644,892	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0.000000	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0.000000	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	924	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0.000000	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	1,179	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,265,088	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1320		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 3/31/2020 9:55 am	
				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		0.306630	0	2,782,258	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.596362	0	338,335	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.140901	0	6,753,885	0	0	54.00
60.00	06000	LABORATORY		0.178675	0	5,338,273	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		1.255249	0	138,109	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.381293	0	3,176,671	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.293166	0	544,229	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.010256	0	6,090	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.737259	0	1,052,140	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.740979	0	158,778	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.335590	0	2,628,327	422	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III		0.000000				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0.000000				0	88.03
88.04	08804	RURAL HEALTH CLINIC V		0.000000				0	88.04
90.00	09000	CLINIC		1.795862	0	51,180	0	0	90.00
90.01	04951	CHEMO/PAIN		1.780029	0	287,805	29	0	90.01
90.02	09002	SENIOR CARE		1.003698	0	610,548	0	0	90.02
90.03	09003	SLEEP LAB		0.462462	0	108,779	0	0	90.03
90.04	09001	ORTHOPEDICS		2.847045	0	108,024	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC		2.187094	0	16,040	0	0	90.05
91.00	09100	EMERGENCY		0.499404	0	1,727,161	151	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		1.875382	0	250,975	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		1.293621		0			95.00
200.00		Subtotal (see instructions)			0	26,077,607	602	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	26,077,607	602	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1320		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 3/31/2020 9:55 am
			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	853,124	0		50.00
53.00	05300	ANESTHESIOLOGY	201,770	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	951,629	0		54.00
60.00	06000	LABORATORY	953,816	0		60.00
65.00	06500	RESPIRATORY THERAPY	173,361	0		65.00
66.00	06600	PHYSICAL THERAPY	1,211,242	0		66.00
69.00	06900	ELECTROCARDIOLOGY	159,549	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	775,700	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	117,651	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	882,040	142		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0		88.04
90.00	09000	CLINIC	91,912	0		90.00
90.01	04951	CHEMO/PAIN	512,301	52		90.01
90.02	09002	SENIOR CARE	612,806	0		90.02
90.03	09003	SLEEP LAB	50,306	0		90.03
90.04	09001	ORTHOPEDICS	307,549	0		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	35,081	0		90.05
91.00	09100	EMERGENCY	862,551	75		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	470,674	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	9,223,124	269		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,223,124	269		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1320

Period:

Worksheet D

Component CCN:14-Z320

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
3/31/2020 9:55 am

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.306630	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.596362	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140901	0	0	0	54.00
60.00	06000	LABORATORY	0.178675	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.255249	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.381293	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.293166	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.010256	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737259	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.740979	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.335590	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000			0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000			0	88.04
90.00	09000	CLINIC	1.795862	0	0	0	90.00
90.01	04951	CHEMO/PAIN	1.780029	0	0	0	90.01
90.02	09002	SENIOR CARE	1.003698	0	0	0	90.02
90.03	09003	SLEEP LAB	0.462462	0	0	0	90.03
90.04	09001	ORTHOPEDICS	2.847045	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	2.187094	0	0	0	90.05
91.00	09100	EMERGENCY	0.499404	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.875382	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.293621		0		95.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1320

Period:

Worksheet D

Component CCN:14-Z320

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
3/31/2020 9:55 am

			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	88.04
90.00	09000	CLINIC	0	0	90.00
90.01	04951	CHEMO/PAIN	0	0	90.01
90.02	09002	SENIOR CARE	0	0	90.02
90.03	09003	SLEEP LAB	0	0	90.03
90.04	09001	ORTHOPEDICS	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	90.05
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
3/31/2020 9:55 am

			Title XIX		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	0.306630	0	0	186,199	0	50.00
53.00	05300	ANESTHESIOLOGY	0.596362	0	0	27,379	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140901	0	0	802,559	0	54.00
60.00	06000	LABORATORY	0.178675	0	0	247,359	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.255249	0	0	6,634	0	65.00
66.00	06600	PHYSICAL THERAPY	0.381293	0	0	355	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.293166	0	0	61,123	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.010256	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737259	0	0	79,473	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.740979	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.335590	0	0	111,405	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1.055040				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.171687				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.799755				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.805344				0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.997443				0	88.04
90.00	09000	CLINIC	1.795862	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	1.780029	0	0	3,991	0	90.01
90.02	09002	SENIOR CARE	1.003698	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.462462	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	2.847045	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	2.187094	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.499404	0	0	355,560	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.875382	0	0	11,039	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1.293621	0	0			95.00
200.00		Subtotal (see instructions)		0	0	1,893,076	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	1,893,076	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
3/31/2020 9:55 am

			Title XIX		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	0	57,094		50.00
53.00	05300	ANESTHESIOLOGY	0	16,328		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	113,081		54.00
60.00	06000	LABORATORY	0	44,197		60.00
65.00	06500	RESPIRATORY THERAPY	0	8,327		65.00
66.00	06600	PHYSICAL THERAPY	0	135		66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,919		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58,592		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,386		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0		88.04
90.00	09000	CLINIC	0	0		90.00
90.01	04951	CHEMO/PAIN	0	7,104		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
90.04	09001	ORTHOPEDICS	0	0		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	177,568		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	20,702		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	558,433		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	558,433		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 3/31/2020 9:55 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,898	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,755	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,974	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,040	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		273	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,170	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)		767	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		149.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		149.97	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,071,787	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)		40,942	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)		1,693,668	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,378,119	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)		4,378,119	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,589.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,859,317	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)		1,859,317	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
3/31/2020 9:55 am

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)					1,369,278	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,228,595	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)					1,218,886	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)					1,218,886	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)					781	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,589.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,241,126	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1320		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 3/31/2020 9:55 am	
		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	679,690	6,071,787	0.111942	1,241,126	138,934	90.00
91.00	Nursing School cost	0	6,071,787	0.000000	1,241,126	0	91.00
92.00	Allied health cost	0	6,071,787	0.000000	1,241,126	0	92.00
93.00	All other Medical Education	0	6,071,787	0.000000	1,241,126	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/31/2020 9:55 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,054,370		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.306630	496,477	152,235	50.00
53.00	05300 ANESTHESIOLOGY	0.596362	99,489	59,331	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140901	433,489	61,079	54.00
60.00	06000 LABORATORY	0.178675	538,150	96,154	60.00
65.00	06500 RESPIRATORY THERAPY	1.255249	189,240	237,543	65.00
66.00	06600 PHYSICAL THERAPY	0.381293	233,615	89,076	66.00
69.00	06900 ELECTROCARDIOLOGY	0.293166	16,443	4,821	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.010256	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737259	342,769	252,710	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.740979	268,421	198,894	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.335590	644,892	216,419	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000 CLINIC	1.795862	0	0	90.00
90.01	04951 CHEMO/PAIN	1.780029	0	0	90.01
90.02	09002 SENIOR CARE	1.003698	0	0	90.02
90.03	09003 SLEEP LAB	0.462462	924	427	90.03
90.04	09001 ORTHOPEDICS	2.847045	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	2.187094	0	0	90.05
91.00	09100 EMERGENCY	0.499404	1,179	589	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.875382	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,265,088	1,369,278	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,265,088		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-1320 Component CCN:14-Z320	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.306630	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.596362	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140901	30,556	4,305	54.00
60.00	06000 LABORATORY	0.178675	128,128	22,893	60.00
65.00	06500 RESPIRATORY THERAPY	1.255249	59,087	74,169	65.00
66.00	06600 PHYSICAL THERAPY	0.381293	406,642	155,050	66.00
69.00	06900 ELECTROCARDIOLOGY	0.293166	1,566	459	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.010256	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737259	45,123	33,267	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.740979	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.335590	224,441	75,320	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000 CLINIC	1.795862	0	0	90.00
90.01	04951 CHEMO/PAIN	1.780029	0	0	90.01
90.02	09002 SENIOR CARE	1.003698	0	0	90.02
90.03	09003 SLEEP LAB	0.462462	0	0	90.03
90.04	09001 ORTHOPEDICS	2.847045	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	2.187094	0	0	90.05
91.00	09100 EMERGENCY	0.499404	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.875382	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		895,543	365,463	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		895,543		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XIX	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		38,670		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.306630	11,024	3,380	50.00
53.00	05300 ANESTHESIOLOGY	0.596362	1,976	1,178	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140901	33,334	4,697	54.00
60.00	06000 LABORATORY	0.178675	30,187	5,394	60.00
65.00	06500 RESPIRATORY THERAPY	1.255249	1,925	2,416	65.00
66.00	06600 PHYSICAL THERAPY	0.381293	6,539	2,493	66.00
69.00	06900 ELECTROCARDIOLOGY	0.293166	2,960	868	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.010256	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737259	9,383	6,918	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.740979	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.335590	33,455	11,227	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.055040	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.171687	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	1.799755	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.805344	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.997443	0	0	88.04
90.00	09000 CLINIC	1.795862	0	0	90.00
90.01	04951 CHEMO/PAIN	1.780029	0	0	90.01
90.02	09002 SENIOR CARE	1.003698	0	0	90.02
90.03	09003 SLEEP LAB	0.462462	0	0	90.03
90.04	09001 ORTHOPEDICS	2.847045	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	2.187094	0	0	90.05
91.00	09100 EMERGENCY	0.499404	6,592	3,292	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.875382	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		137,375	41,863	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		137,375		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 3/31/2020 9:55 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		9,223,393	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)		9,223,393	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)		9,315,627	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)		45,887	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,119,631	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)		5,150,109	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)		5,150,109	30.00
31.00	Primary payer payments		1,168	31.00
32.00	Subtotal (line 30 minus line 31)		5,148,941	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)		274,640	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		178,516	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		40,291	36.00
37.00	Subtotal (see instructions)		5,327,457	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)		5,327,457	40.00
40.01	Sequestration adjustment (see instructions)		106,549	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,511,897	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		709,011	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		96,124	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: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
3/31/2020 9:55 am

		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		3,199,987		4,511,897	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,199,987		4,511,897	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		709,011	6.01
6.02	SETTLEMENT TO PROGRAM		328,423		0	6.02
7.00	Total Medicare program liability (see instructions)		2,871,564		5,220,908	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: 14-1320

Period:

Worksheet E-1

Component CCN: 14-Z320

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
3/31/2020 9:55 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,799,147		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,799,147		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		242,485		0	6.02
7.00	Total Medicare program liability (see instructions)		1,556,662		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: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
3/31/2020 9:55 am

		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:14-1320

Period:

Worksheet E-2

Component CCN:14-Z320

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,231,075	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		369,118	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		767	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,600,193	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,600,193	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,600,193	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		11,762	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,588,431	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,588,431	0	19.00
19.01	Sequestration adjustment (see instructions)		31,769	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,799,147	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-242,485	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 3/31/2020 9:55 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,228,595	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)		3,228,595	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,260,881	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)		3,260,881	19.00
20.00	Deductibles (exclude professional component)		362,934	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,897,947	22.00
23.00	Coinsurance		341	23.00
24.00	Subtotal (line 22 minus line 23)		2,897,606	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		50,094	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		32,561	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,930,167	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)		2,930,167	30.00
30.01	Sequestration adjustment (see instructions)		58,603	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		3,199,987	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-328,423	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		17,533	34.00

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

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet G

Date/Time Prepared:
3/31/2020 9:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,764,530	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	25,916,249	0	0	0	4.00
5.00	Other receivable	2,197,331	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-16,406,610	0	0	0	6.00
7.00	Inventory	1,698,498	0	0	0	7.00
8.00	Prepaid expenses	872,732	0	0	0	8.00
9.00	Other current assets	0	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)	17,042,730	0	0	0	11.00
FIXED ASSETS						
12.00	Land	324,175	0	0	0	12.00
13.00	Land improvements	2,523,630	0	0	0	13.00
14.00	Accumulated depreciation	-1,826,208	0	0	0	14.00
15.00	Buildings	41,036,652	0	0	0	15.00
16.00	Accumulated depreciation	-18,761,916	0	0	0	16.00
17.00	Leasehold improvements	3,770,873	0	0	0	17.00
18.00	Accumulated depreciation	-74,744	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	21,057,249	0	0	0	23.00
24.00	Accumulated depreciation	-15,744,612	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	32,305,099	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,347,829	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,018,783	0	0	0	37.00
38.00	Salaries, wages, and fees payable	-2,922	0	0	0	38.00
39.00	Payroll taxes payable	2,301,662	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,377,320	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	70,216	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,765,059	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	235,160	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)	235,160	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,000,219	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	35,347,610				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	35,347,610	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,347,829	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-1

Date/Time Prepared:
3/31/2020 9:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		33,047,449		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		866,083				2.00
3.00	Total (sum of line 1 and line 2)		33,913,532		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)		33,913,532		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		33,913,532		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	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
3/31/2020 9:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,539,148		4,539,148	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)	4,539,148		4,539,148	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,539,148		4,539,148	17.00
18.00	Ancillary services	7,668,696	79,500,495	87,169,191	18.00
19.00	Outpatient services	0	13,231,942	13,231,942	19.00
20.00	RURAL HEALTH CLINIC	106,599	12,863,580	12,970,179	20.00
20.01	RURAL HEALTH CLINIC II	0	479,828	479,828	20.01
20.02	RURAL HEALTH CLINIC III	0	455,211	455,211	20.02
20.03	RURAL HEALTH CLINIC IV	0	462,641	462,641	20.03
20.04	RURAL HEALTH CLINIC V	0	2,257,536	2,257,536	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,443,533	1,443,533	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	0	255,708	255,708	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,314,443	110,950,474	123,264,917	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		60,911,174		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)		60,911,174		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-3

Date/Time Prepared:
3/31/2020 9:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	123,264,917	1.00
2.00	Less contractual allowances and discounts on patients' accounts	65,830,753	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,434,164	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,911,174	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,477,010	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	105,550	6.00
7.00	Income from investments	132,058	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	4,619	10.00
11.00	Rebates and refunds of expenses	40,652	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	111,930	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	10,756	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	55,399	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	684,394	24.00
24.01	PHARMACY	3,120,236	24.01
24.02	PRO FEES	114,466	24.02
24.03	PHYSICIAN ADMITTING	0	24.03
24.04	GAIN/LOSS ON SALE	-36,967	24.04
25.00	Total other income (sum of lines 6-24)	4,343,093	25.00
26.00	Total (line 5 plus line 25)	866,083	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	866,083	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3987

From 01/01/2019
To 12/31/2019

Date/Time Prepared:

3/31/2020 9:55 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,759,760	0	3,759,760	0	3,759,760
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	977,472	0	977,472	0	977,472
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	2,064,546	0	2,064,546	0	2,064,546
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	6,801,778	0	6,801,778	0	6,801,778
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	81,008	81,008	0	81,008
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	220,310	220,310	0	220,310
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	301,318	301,318	0	301,318
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	6,801,778	301,318	7,103,096	0	7,103,096
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	107,237	107,237	0	107,237
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	107,237	107,237	0	107,237
FACILITY OVERHEAD						
29.00	Facility Costs	0	505,798	505,798	0	505,798
30.00	Administrative Costs	856,743	2,658,263	3,515,006	0	3,515,006
31.00	Total Facility Overhead (sum of lines 29 and 30)	856,743	3,164,061	4,020,804	0	4,020,804
32.00	Total facility costs (sum of lines 22, 28 and 31)	7,658,521	3,572,616	11,231,137	0	11,231,137

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3987

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	3,759,760	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	977,472	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	2,064,546	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	6,801,778	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	81,008	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	220,310	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	301,318	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	7,103,096	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	-94,466	12,771	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-94,466	12,771	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	505,798	29.00
30.00	Administrative Costs	-27,494	3,487,512	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-27,494	3,993,310	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-121,960	11,109,177	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3989

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	187,929	0	187,929	0	187,929
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	77,157	0	77,157	0	77,157
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	265,086	0	265,086	0	265,086
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	13,115	13,115	0	13,115
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	25,665	25,665	0	25,665
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	38,780	38,780	0	38,780
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	265,086	38,780	303,866	0	303,866
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	3,804	3,804	0	3,804
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,804	3,804	0	3,804
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,066	1,066	0	1,066
30.00	Administrative Costs	43,571	131,473	175,044	0	175,044
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,571	132,539	176,110	0	176,110
32.00	Total facility costs (sum of lines 22, 28 and 31)	308,657	175,123	483,780	0	483,780

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3989

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	187,929	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	77,157	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	265,086	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	13,115	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	25,665	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,780	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	303,866	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	-3,804	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	-3,804	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	1,066	29.00
30.00	Administrative Costs	0	175,044	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	176,110	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,804	479,976	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8596

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	284,895	0	284,895	0	284,895
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	76,296	0	76,296	0	76,296
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	39,705	0	39,705	0	39,705
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	400,896	0	400,896	0	400,896
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	530	530	0	530
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	6,234	6,234	0	6,234
19.00	Other Health Care Costs	0	739	739	0	739
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	7,503	7,503	0	7,503
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	400,896	7,503	408,399	0	408,399
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	24,580	24,580	0	24,580
30.00	Administrative Costs	32,332	93,908	126,240	0	126,240
31.00	Total Facility Overhead (sum of lines 29 and 30)	32,332	118,488	150,820	0	150,820
32.00	Total facility costs (sum of lines 22, 28 and 31)	433,228	125,991	559,219	0	559,219

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8596

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	284,895	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	76,296	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	39,705	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	400,896	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	530	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	6,234	18.00
19.00	Other Health Care Costs	0	739	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,503	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	408,399	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	24,580	29.00
30.00	Administrative Costs	0	126,240	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	150,820	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	559,219	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8607

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

3/31/2020 9:55 am

		RHC IV		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	167,273	0	167,273	0	167,273
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	44,233	0	44,233	0	44,233
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	211,506	0	211,506	0	211,506
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	22,790	22,790	0	22,790
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	22,790	22,790	0	22,790
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	211,506	22,790	234,296	0	234,296
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	60	60	0	60
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	60	60	0	60
FACILITY OVERHEAD						
29.00	Facility Costs	0	319	319	0	319
30.00	Administrative Costs	37,524	93,987	131,511	0	131,511
31.00	Total Facility Overhead (sum of lines 29 and 30)	37,524	94,306	131,830	0	131,830
32.00	Total facility costs (sum of lines 22, 28 and 31)	249,030	117,156	366,186	0	366,186

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8607

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

RHC IV

Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00 Physician	0	0	1.00
2.00 Physician Assistant	0	0	2.00
3.00 Nurse Practitioner	0	167,273	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	44,233	5.00
6.00 Clinical Psychologist	0	0	6.00
7.00 Clinical Social Worker	0	0	7.00
8.00 Laboratory Technician	0	0	8.00
9.00 Other Facility Health Care Staff Costs	0	0	9.00
10.00 Subtotal (sum of lines 1 through 9)	0	211,506	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	22,790	15.00
16.00 Transportation (Health Care Staff)	0	0	16.00
17.00 Depreciation-Medical Equipment	0	0	17.00
18.00 Professional Liability Insurance	0	0	18.00
19.00 Other Health Care Costs	0	0	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	22,790	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	234,296	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	60	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	60	28.00
FACILITY OVERHEAD			
29.00 Facility Costs	0	319	29.00
30.00 Administrative Costs	0	131,511	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	0	131,830	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	0	366,186	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8606

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC V		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	16,223	0	16,223	0	16,223 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	5,721	0	5,721	0	5,721 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	21,944	0	21,944	0	21,944 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	1,496	1,496	0	1,496 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	0	0	0	0 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,496	1,496	0	1,496 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	21,944	1,496	23,440	0	23,440 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	962	962	0	962 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	962	962	0	962 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0 29.00
30.00	Administrative Costs	5,227	11,995	17,222	0	17,222 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	5,227	11,995	17,222	0	17,222 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	27,171	14,453	41,624	0	41,624 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8606

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC V		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	16,223	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	5,721	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	21,944	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	1,496	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,496	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	23,440	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	962	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	962	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	17,222	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	17,222	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	41,624	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-3987

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	6.41	29,977	4,200	26,922	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	6.50	14,200	2,100	13,650	3.00
4.00	Subtotal (sum of lines 1 through 3)	12.91	44,177		40,572	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)	12.91	44,177		44,177	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)				7,103,096	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				12,771	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				7,115,867	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.998205	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				3,993,310	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,903,304	15.00
16.00	Total overhead (sum of lines 14 and 15)				5,896,614	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				5,896,614	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				5,886,030	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				12,989,126	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-3989

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.32	2,687	2,100	2,772		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.32	2,687		2,772	2,772	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)	1.32	2,687			2,772	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)					303,866	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)					303,866	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)					176,110	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					82,232	15.00
16.00	Total overhead (sum of lines 14 and 15)					258,342	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					258,342	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					258,342	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					562,208	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8596

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.47	1,138	3,625	1,704		1.00
2.00	Physician Assistant	0.00	0	1,812	0		2.00
3.00	Nurse Practitioner	0.68	982	1,812	1,232		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.15	2,120		2,936	2,936	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)	1.15	2,120			2,936	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)					408,399	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)					408,399	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)					150,820	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					95,809	15.00
16.00	Total overhead (sum of lines 14 and 15)					246,629	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					246,629	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					246,629	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					655,028	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8607

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

		RHC IV		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.17	29	1,116	190
2.00	Physician Assistant	0.52	680	558	290
3.00	Nurse Practitioner	0.53	999	558	296
4.00	Subtotal (sum of lines 1 through 3)	1.22	1,708	776	1,708
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.22	1,708		1,708
9.00	Physician Services Under Agreements		0		0
					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)				234,296
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				60
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				234,356
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.999744
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				131,830
15.00	Parent provider overhead allocated to facility (see instructions)				62,737
16.00	Total overhead (sum of lines 14 and 15)				194,567
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				194,567
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				194,517
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				428,813

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8606

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/31/2020 9:55 am

				RHC V		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	552	0		1.00
2.00	Physician Assistant	0.04	144	276	11		2.00
3.00	Nurse Practitioner	0.11	240	276	30		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.15	384		41	384	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.15	384			384	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)					23,440	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					962	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					24,402	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.960577	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					17,222	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					7,131	15.00
16.00	Total overhead (sum of lines 14 and 15)					24,353	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					24,353	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					23,393	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					46,833	20.00

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3	
		Component CCN:14-3987		Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			12,989,126	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			338,457	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			12,650,669	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			44,177	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)			44,177	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			286.36	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		286.36	286.36	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	13,434	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	3,846,960	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	3,846,960	16.00
16.01	Total program charges (see instructions)(from contractor's records)			2,193,634	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			77,442	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			135,809	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			2,835,549	16.04
16.05	Total program cost (see instructions)		0	2,971,358	16.05
17.00	Primary payer amounts			438	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			166,715	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			389,895	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			2,970,920	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			127,025	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			3,097,945	22.00
23.00	Allowable bad debts (see instructions)			118,684	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			77,145	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			92,851	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)			3,175,090	26.00
26.01	Sequestration adjustment (see instructions)			63,502	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			2,254,570	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)			857,018	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			562,208	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			25,703	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			536,505	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,772	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,772	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			193.54	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		193.54	193.54	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	431	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	83,416	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	83,416	16.00
16.01	Total program charges (see instructions)(from contractor's records)			61,019	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			4,664	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			6,376	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.)			56,084	16.04
16.05	Total program cost (see instructions)		0	62,460	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			6,935	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			9,884	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			62,460	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,680	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			73,140	22.00
23.00	Allowable bad debts (see instructions)			4,427	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			2,878	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,851	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)			76,018	26.00
26.01	Sequestration adjustment (see instructions)			1,520	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			50,361	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)			24,137	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-8596	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC III	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)			655,028	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			20,129	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			634,899	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,936	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,936	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			216.25	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		216.25	216.25	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	669	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	144,671	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	144,671	16.00
16.01	Total program charges (see instructions)(from contractor's records)			101,710	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			7,906	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			11,245	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.)			102,753	16.04
16.05	Total program cost (see instructions)		0	113,998	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			4,985	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			17,764	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			113,998	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			7,763	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			121,761	22.00
23.00	Allowable bad debts (see instructions)			396	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			257	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			100	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)			122,018	26.00
26.01	Sequestration adjustment (see instructions)			2,440	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			22,391	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)			97,187	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-8607	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 3/31/2020 9:55 am		
		Title XVIII	RHC IV	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)			428,813	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			1,100	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			427,713	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,708	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)			1,708	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			250.42	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			250.42	250.42	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	93	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	23,289	11.00	
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00	
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00	
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00	
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00	
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	23,289	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			17,744	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			17,891	16.04	
16.05	Total program cost (see instructions)		0	17,891	16.05	
17.00	Primary payer amounts			15	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			925	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			3,364	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			17,876	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			169	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			18,045	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)			18,045	26.00	
26.01	Sequestration adjustment (see instructions)			361	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			2,792	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)			14,892	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

Health Financial Systems		PARIS COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3	
		Component CCN:14-8606		Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC V	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)			46,833	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			176	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			46,657	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			384	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)			384	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			121.50	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		121.50	121.50	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	122	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	122	16.00
16.01	Total program charges (see instructions)(from contractor's records)			132	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			-8	16.04
16.05	Total program cost (see instructions)		0	-8	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			132	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			-8	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			-8	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)			-8	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			-82	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)			74	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1320 Component CCN:14-3987	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		6,801,778	6,801,778	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003836	0.006405	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		26,092	43,565	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		82,114	33,313	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		108,206	76,878	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		7,103,096	7,103,096	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		5,886,030	5,886,030	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.015234	0.010823	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		89,668	63,705	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		197,874	140,583	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		618	1,032	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		320.18	136.22	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		224	406	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		71,720	55,305	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			338,457	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			127,025	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1320 Component CCN:14-3989	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		265,086	265,086	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003035	0.010257	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		805	2,719	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		7,502	2,866	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		8,307	5,585	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		303,866	303,866	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		258,342	258,342	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.027338	0.018380	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,063	4,748	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		15,370	10,333	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		50	169	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		307.40	61.14	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		24	54	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		7,378	3,302	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			25,703	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			10,680	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1320 Component CCN:14-8596	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		400,896	400,896	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001603	0.010242	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		643	4,106	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,056	4,745	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,699	8,851	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		408,399	408,399	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		246,629	246,629	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.009057	0.021672	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		2,234	5,345	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		5,933	14,196	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		23	147	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		257.96	96.57	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		11	51	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,838	4,925	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			20,129	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			7,763	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1320 Component CCN:14-8607	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC IV	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		211,506	211,506	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000854	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	181	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	420	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	601	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		234,296	234,296	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		194,517	194,517	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.002565	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	499	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	1,100	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	13	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	84.62	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	2	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	169	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			1,100	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			169	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1320 Component CCN:14-8606	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/31/2020 9:55 am	
		Title XVIII	RHC V	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		21,944	21,944	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.001068	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	23	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	65	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	88	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		23,440	23,440	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		23,393	23,393	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.003754	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	88	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	176	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	2	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	88.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			176	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/31/2020 9:55 am	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			2,151,802	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			07/25/2019	102,768	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)			102,768	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			2,254,570	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			857,018	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			3,111,588	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1320 Component CCN:14-3989	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/31/2020 9:55 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			50,361	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			50,361	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			24,137	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			74,498	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1320 Component CCN:14-8596	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/31/2020 9:55 am	
			RHC III	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		22,391	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		22,391		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		97,187		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		119,578		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1320 Component CCN:14-8607	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/31/2020 9:55 am	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			2,792	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			2,792	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			14,892	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			17,684	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1320 Component CCN: 14-8606	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/31/2020 9:55 am	
			RHC V	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		-82	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		-82	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		74	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		-8	7.00	
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00