

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/6/2021 2:05 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/6/2021	Time: 2:05 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARIS COMMUNITY HOSPITAL (14-1320) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) 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	489,653	719,949	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	206,531	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		370,735		0	10.00
10.01	RURAL HEALTH CLINIC II	0		30,273		0	10.01
10.02	RURAL HEALTH CLINIC III	0		86,894		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		59,944		0	10.03
10.04	RURAL HEALTH CLINIC V	0		58		0	10.04
200.00	Total	0	696,184	1,267,853	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 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/6/2021 2:05 pm	
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 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		PARIS COMMUNITY HOSPITAL	141320	99914	1	06/30/2002	N	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
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
15.01	Hospital-Based Health Clinic - RHC		HATCH	143989	99914		01/01/1995	N	O
15.02	Hospital-Based Health Clinic - RHC		FMC OAKLAND	148596	99914		02/22/2019	N	O
15.03	Hospital-Based Health Clinic - RHC		EZ CARE - PARIS	148607	99914		09/25/2019	N	O
15.04	Hospital-Based Health Clinic - RHC		EZ CARE MARSHALL	148606	99914		11/14/2019	N	O
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)						01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)						2		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
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.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/6/2021 2:05 pm			
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
		1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00		
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
		1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
						1.00			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
		1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
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	
			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
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
						75.00
						76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/6/2021 2:05 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/6/2021 2:05 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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:	338,057	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1320		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/6/2021 2:05 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	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.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/6/2021 2:05 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/13/2021	N
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
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/6/2021 2:05 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
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 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/6/2021 2:05 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	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 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	39,672.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	39,672.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	39,672.00	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 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,134	6	1,653			1.00
2.00	HMO and other (see instructions)	157	123				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	647	0	885			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	1,481			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,781	6	4,019			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)	1,781	6	4,019	0.00	339.72	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	12,015	0	41,275	0.00	77.57	26.00
26.01	RURAL HEALTH CLINIC II	457	0	2,963	0.00	5.09	26.01
26.02	RURAL HEALTH CLINIC III	683	0	2,300	0.00	3.78	26.02
26.03	RURAL HEALTH CLINIC IV	1,149	0	12,462	0.00	21.43	26.03
26.04	RURAL HEALTH CLINIC V	510	0	5,202	0.00	5.20	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	452.79	27.00
28.00	Observation Bed Days		0	1,032			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	351	2	518	1.00
2.00 HMO and other (see instructions)			54	41		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	351	2	518	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 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 7/6/2021 2:05 pm	
		RHC I		Cost	
		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	
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	
9.01				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
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				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: 14-3987

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

						RHC I		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		
11.00	Facility hours of operations (1)									11.00
	CLINIC			17:00	08:00	19:00	08:00	19:00		
				Friday		Saturday				
				from	to	from	to			
				11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)									11.00
	CLINIC			08:00	19:00	08:00	11:30			

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 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 7/6/2021 2:05 pm	
		RHC II		Cost	
		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	
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	
9.01				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	
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)		Tuesday		from	
11.00	CLINIC	08:00		12:00 13:30 11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		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 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

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

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: 14-8596		Period: From 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 7/6/2021 2:05 pm	
		RHC III		Cost	
		1.00			
1.00	Clinic Address and Identification	721 EAST COURT ST			
	Street				
		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				
5.00	Community Health Center (Section 330(d), PHS Act)				
6.00	Migrant Health Center (Section 329(d), PHS Act)				
7.00	Health Services for the Homeless (Section 340(d), PHS Act)				
8.00	Appalachian Regional Commission				
9.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)				
11.00	CLINIC	08:00	17:00	08:00	11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	EDGAR		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
11.00	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

Period:

Worksheet S-8

Component CCN: 14-8596

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		RHC III		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1)				
	CLINIC	08:00	19:00	08:00	11:30
					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 Component CCN: 14-8607		Period: From 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 7/6/2021 2:05 pm	
		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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		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?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	EDGAR		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
11.00	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 01/01/2020	Worksheet S-8
			Component CCN: 14-8607	To 12/31/2020	Date/Time Prepared: 7/6/2021 2:05 pm
			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

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: 14-8606		Period: From 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 7/6/2021 2:05 pm	
		RHC V		Cost	
		1.00			
1.00	Clinic Address and Identification				
	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	
4.00	Source of Federal Funds				
5.00	Community Health Center (Section 330(d), PHS Act)	4.00			
6.00	Migrant Health Center (Section 329(d), PHS Act)	5.00			
7.00	Health Services for the Homeless (Section 340(d), PHS Act)	6.00			
8.00	Appalachian Regional Commission	7.00			
9.00	Look-Alikes	8.00			
9.00	OTHER (SPECIFY)	9.00			
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)				
	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?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	15.00			
		County			
		4.00			
2.00	City, State, ZIP Code, County	CLARK		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
11.00	Facility hours of operations (1)				
	CLINIC	17:00	08:00	19:00	08:00
		19:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320

Period:

Worksheet S-8

Component CCN: 14-8606

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

				RHC V		Cost	
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	08:00	19:00	08:00	11:30		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-10

Date/Time Prepared:
7/6/2021 2:05 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.528807	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		5,996,997	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		29,162,520	6.00
7.00	Medicaid cost (line 1 times line 6)		15,421,345	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)		9,424,348	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)		9,424,348	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,634,732	0	1,634,732
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	864,458	0	864,458
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	864,458	0	864,458
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,752,784	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		317,683	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		488,743	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,264,041	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,368,301	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,232,759	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		11,657,107	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,600,413	1,600,413	657,965	2,258,378	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,668,765	1,668,765	124,062	1,792,827	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	215,781	219,926	435,707	1,879,092	2,314,799	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	4,633,511	8,567,743	13,201,254	-2,115,288	11,085,966	5.01
5.02	00560	ADMITTING	1,294,344	1,139,365	2,433,709	-864	2,432,845	5.02
7.00	00700	OPERATION OF PLANT	600,161	1,014,503	1,614,664	-1,566	1,613,098	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,948	97,948	0	97,948	8.00
9.00	00900	HOUSEKEEPING	512,235	436,682	948,917	0	948,917	9.00
10.00	01000	DIETARY	492,623	411,363	903,986	-637,725	266,261	10.00
11.00	01100	CAFETERIA	0	0	0	637,039	637,039	11.00
13.00	01300	NURSING ADMINISTRATION	403,012	50,381	453,393	0	453,393	13.00
15.00	01500	PHARMACY	307,628	1,893,598	2,201,226	-1,773,037	428,189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478,423	99,888	578,311	0	578,311	16.00
17.00	01700	SOCIAL SERVICE	98,091	8,859	106,950	0	106,950	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,127,692	184,656	3,312,348	-46,285	3,266,063	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,456,036	1,878,960	3,334,996	-2,063,509	1,271,487	50.00
53.00	05300	ANESTHESIOLOGY	2,080,085	352,220	2,432,305	-291,586	2,140,719	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,508,611	1,090,248	2,598,859	-232,217	2,366,642	54.00
60.00	06000	LABORATORY	790,309	1,948,334	2,738,643	-755,902	1,982,741	60.00
65.00	06500	RESPIRATORY THERAPY	597,847	163,634	761,481	-56,790	704,691	65.00
66.00	06600	PHYSICAL THERAPY	1,248,825	189,587	1,438,412	-1,214	1,437,198	66.00
69.00	06900	ELECTROCARDIOLOGY	0	74,030	74,030	62,738	136,768	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,482	1,482	0	1,482	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,689,681	2,689,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	824,848	824,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,870,926	1,870,926	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,901,886	2,687,537	10,589,423	0	10,589,423	88.00
88.01	08801	RURAL HEALTH CLINIC II	360,832	175,081	535,913	0	535,913	88.01
88.02	08802	RURAL HEALTH CLINIC III	523,930	145,383	669,313	0	669,313	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,008,127	919,771	2,927,898	0	2,927,898	88.03
88.04	08804	RURAL HEALTH CLINIC V	371,829	114,837	486,666	0	486,666	88.04
90.00	09000	CLINIC	147,631	34,483	182,114	-14,720	167,394	90.00
90.01	04951	CHEMO/PAIN	873,470	552,101	1,425,571	-161,478	1,264,093	90.01
90.02	09002	SENIOR CARE	6,983	522,632	529,615	-23,921	505,694	90.02
90.03	09003	SLEEP LAB	72,275	58,914	131,189	-556	130,633	90.03
90.04	09001	ORTHOPEDICS	1,300,761	187,683	1,488,444	-12,910	1,475,534	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	87,803	253,596	341,399	0	341,399	90.05
91.00	09100	EMERGENCY	1,841,849	1,990,613	3,832,462	-43,806	3,788,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,242,332	339,906	1,582,238	-12,192	1,570,046	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		500,785	500,785	-500,785	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,584,922	31,575,907	68,160,829	0	68,160,829	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	106,102	42,907	149,009	0	149,009	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	317,082	96,929	414,011	0	414,011	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		TOTAL (SUM OF LINES 118 through 199)	37,008,106	31,715,743	68,723,849	0	68,723,849	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/6/2021 2:05 pm

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	-75,083	2,183,295	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,792,827	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-175,950	2,138,849	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-465,877	10,620,089	5.01
5.02	00560	ADMITTING	-36	2,432,809	5.02
7.00	00700	OPERATION OF PLANT	-6,500	1,606,598	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-300	97,648	8.00
9.00	00900	HOUSEKEEPING	-256	948,661	9.00
10.00	01000	DIETARY	-44,927	221,334	10.00
11.00	01100	CAFETERIA	-109,396	527,643	11.00
13.00	01300	NURSING ADMINISTRATION	0	453,393	13.00
15.00	01500	PHARMACY	69,093	497,282	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,648	573,663	16.00
17.00	01700	SOCIAL SERVICE	0	106,950	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-613,237	2,652,826	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-500	1,270,987	50.00
53.00	05300	ANESTHESIOLOGY	-1,603,651	537,068	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-623,481	1,743,161	54.00
60.00	06000	LABORATORY	-631	1,982,110	60.00
65.00	06500	RESPIRATORY THERAPY	0	704,691	65.00
66.00	06600	PHYSICAL THERAPY	-3,036	1,434,162	66.00
69.00	06900	ELECTROCARDIOLOGY	-59,680	77,088	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,482	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,689,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	824,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-20,308	1,850,618	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-126,982	10,462,441	88.00
88.01	08801	RURAL HEALTH CLINIC II	-1,279	534,634	88.01
88.02	08802	RURAL HEALTH CLINIC III	-723	668,590	88.02
88.03	08803	RURAL HEALTH CLINIC IV	490	2,928,388	88.03
88.04	08804	RURAL HEALTH CLINIC V	-9,695	476,971	88.04
90.00	09000	CLINIC	0	167,394	90.00
90.01	04951	CHEMO/PAIN	-227,790	1,036,303	90.01
90.02	09002	SENIOR CARE	-4,566	501,128	90.02
90.03	09003	SLEEP LAB	-23,276	107,357	90.03
90.04	09001	ORTHOPEDICS	-1,131,799	343,735	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	-52,738	288,661	90.05
91.00	09100	EMERGENCY	-1,351,813	2,436,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-4,636	1,565,410	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,674,693	61,486,136	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	149,009	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	192.01
192.02	19201	NAL CLINIC	0	414,011	192.02
192.03	19203	OAKLAND CLINIC	0	0	192.03
192.04	19204	EZ CARE CLINIC	0	0	192.04
192.05	19205	MARSHALL EZ CARE CLINIC	0	0	192.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,674,693	62,049,156	200.00

RECLASSIFICATIONS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/6/2021 2:05 pm

		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	124,062		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
13.00		0.00	0	0		13.00
	0		0	124,062		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	347,151	289,888		1.00
	0		347,151	289,888		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	48,212	0		1.00
2.00		0.00	0	0		2.00
	0		48,212	0		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	157,180		1.00
	0		0	157,180		
	E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,689,681		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
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	2,689,681		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,870,926		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
13.00		0.00	0	0		13.00
	0		0	1,870,926		
	I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	11,788	2,738		1.00
	0		11,788	2,738		
	J - IMPLANT EXPENSE					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	824,848		1.00
	0		0	824,848		
	K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	500,785		1.00
	0		0	500,785		

RECLASSIFICATIONS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/6/2021 2:05 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,879,206		1.00
	0		0	1,879,206		
500.00	Grand Total: Increases		407,151	8,339,314		500.00

RECLASSIFICATIONS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/6/2021 2:05 pm

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	114	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	49,528	0		2.00
3.00	ADMITTING	5.02	0	573	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1,551	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	6,785	0		5.00
6.00	OPERATING ROOM	50.00	0	25,818	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	372	0		7.00
8.00	LABORATORY	60.00	0	136	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	9,806	0		9.00
10.00	CHEMO/PAIN	90.01	0	909	0		10.00
11.00	SENIOR CARE	90.02	0	23,921	0		11.00
12.00	SLEEP LAB	90.03	0	540	0		12.00
13.00	AMBULANCE SERVICES	95.00	0	4,009	0		13.00
	0		0	124,062			
	B - CAFETERIA						
1.00	DIETARY	10.00	347,151	289,888	0		1.00
	0		347,151	289,888			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	11,561	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	36,651	0	0		2.00
	0		48,212	0			
	D - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	157,180	12		1.00
	0		0	157,180			
	E - OXYGEN/PATIENT SUPPLIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	29,374	0		1.00
2.00	ADMITTING	5.02	0	291	0		2.00
3.00	OPERATION OF PLANT	7.00	0	15	0		3.00
4.00	DIETARY	10.00	0	619	0		4.00
5.00	PHARMACY	15.00	0	27,917	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	27,683	0		6.00
7.00	OPERATING ROOM	50.00	0	1,212,376	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	257,122	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	229,272	0		9.00
10.00	LABORATORY	60.00	0	755,763	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	9,277	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	974	0		12.00
13.00	CLINIC	90.00	0	127	0		13.00
14.00	CHEMO/PAIN	90.01	0	78,556	0		14.00
15.00	SLEEP LAB	90.03	0	16	0		15.00
16.00	ORTHOPEDICS	90.04	0	12,910	0		16.00
17.00	EMERGENCY	91.00	0	42,099	0		17.00
18.00	AMBULANCE SERVICES	95.00	0	5,290	0		18.00
	0		0	2,689,681			
	F - DRUGS						
1.00	DIETARY	10.00	0	67	0		1.00
2.00	PHARMACY	15.00	0	1,745,120	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	256	0		3.00
4.00	OPERATING ROOM	50.00	0	467	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	34,092	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,945	0		6.00
7.00	LABORATORY	60.00	0	3	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	1,056	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	240	0		9.00
10.00	CLINIC	90.00	0	67	0		10.00
11.00	CHEMO/PAIN	90.01	0	82,013	0		11.00
12.00	EMERGENCY	91.00	0	1,707	0		12.00
13.00	AMBULANCE SERVICES	95.00	0	2,893	0		13.00
	0		0	1,870,926			
	I - STRESS TEST						
1.00	CLINIC	90.00	11,788	2,738	0		1.00
	0		11,788	2,738			
	J - IMPLANT EXPENSE						
1.00	OPERATING ROOM	50.00	0	824,848	0		1.00
	0		0	824,848			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	500,785	9		1.00
	0		0	500,785			

RECLASSIFICATIONS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/6/2021 2:05 pm

	Decreases						1/10/2021 2:00 pm
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	L - BENEFITS RECLASS						
	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1,879,206	0		1.00
	0		0	1,879,206			
500.00	Grand Total: Decreases		407,151	8,339,314			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	324,175	177,657	0	177,657	0	1.00	
2.00	Land Improvements	2,523,630	615,374	0	615,374	0	2.00	
3.00	Buildings and Fixtures	41,036,652	8,649,644	0	8,649,644	0	3.00	
4.00	Building Improvements	3,770,873	0	0	0	1,993,317	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	21,057,249	2,052,309	0	2,052,309	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	68,712,579	11,494,984	0	11,494,984	1,993,317	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	68,712,579	11,494,984	0	11,494,984	1,993,317	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	501,832	0					1.00
2.00	Land Improvements	3,139,004	0					2.00
3.00	Buildings and Fixtures	49,686,296	0					3.00
4.00	Building Improvements	1,777,556	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	23,109,558	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	78,214,246	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	78,214,246	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,600,413	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,668,765	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,269,178	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,600,413				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,668,765				2.00
3.00	Total (sum of lines 1-2)	0	3,269,178				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	55,104,688	0	55,104,688	0.704535	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	23,109,558	0	23,109,558	0.295465	0	2.00
3.00	Total (sum of lines 1-2)	78,214,246	0	78,214,246	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,026,115	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,668,765	124,062	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,694,880	124,062	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	157,180	0	0	2,183,295	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,792,827	2.00
3.00	Total (sum of lines 1-2)	0	157,180	0	0	3,976,122	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		A	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-75,083	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	-1,957	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-2,787	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	-4,047,254			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	-109,396	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-149,046	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	-20,308	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,621	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
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADMINISTRATIVE AND GENERAL-ADV	A	-124,739	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
34.00	ANESTHESIA-ADVERTISING	A	-172	ANESTHESIOLOGY	53.00	0	34.00
34.01	RURAL HEALTH CLINIC-ADVERTISING	A	-92,208	RURAL HEALTH CLINIC	88.00	0	34.01
34.02	RURAL HEALTH CLINIC II-ADVERTISING	A	-1,279	RURAL HEALTH CLINIC II	88.01	0	34.02
34.03	RURAL HEALTH CLINIC III-ADVERTISING	A	-603	RURAL HEALTH CLINIC III	88.02	0	34.03
34.04	RURAL HEALTH CLINIC IV-ADVERTISING	A	-30	RURAL HEALTH CLINIC IV	88.03	0	34.04
34.05	RURAL HEALTH CLINIC V-ADVERTISING	A	-9,075	RURAL HEALTH CLINIC V	88.04	0	34.05
34.06	SENIOR CARE-ADVERTISING	A	-4,559	SENIOR CARE	90.02	0	34.06
34.07	BEHAVIORAL HEALTH-ADVERTISING	A	-238	BEHAVIORAL HEALTH CLINIC	90.05	0	34.07
34.08	AMBULANCE SERVICES-ADVERTISING	A	-3,955	AMBULANCE SERVICES	95.00	0	34.08
34.09	OTHER ADMINISTRATIVE AND GENERAL-NON	A	-20,096	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	34.09
34.10	RURAL HEALTH CLINIC-NON-ALLOWABLE P	A	-13	RURAL HEALTH CLINIC	88.00	0	34.10
34.11	ANESTHESIA	A	-1,583,786	ANESTHESIOLOGY	53.00	0	34.11
34.12	ANESTHESIA BENEFITS	A	-19,689	ANESTHESIOLOGY	53.00	0	34.12
35.00	ANESTHESIA BENEFITS	A	-175,907	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	EMPLOYEE BENEFITS DEPARTMENT-OTHER R	B	-43	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	OTHER ADMINISTRATIVE AND GENERAL-OTH	B	-153,540	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	36.01
37.00	ADMITTING-OTHER REVEUNUE	B	-36	ADMITTING	5.02	0	37.00
37.01	OPERATION OF PLANT-OTHER REVEUNUE	B	-6,500	OPERATION OF PLANT	7.00	0	37.01
37.02	LAUNDRY & LINEN SERVICE-OTHER REVEUN	B	-300	LAUNDRY & LINEN SERVICE	8.00	0	37.02
37.03	HOUSEKEEPING-OTHER REVEUNUE	B	-256	HOUSEKEEPING	9.00	0	37.03
37.04	DIETARY-OTHER REVEUNUE	B	-44,927	DIETARY	10.00	0	37.04
37.05	PHARMACY-OTHER REVEUNUE	B	69,093	PHARMACY	15.00	0	37.05
37.06	MEDICAL RECORDS & LIBRARY-OTHER REVE	B	-27	MEDICAL RECORDS & LIBRARY	16.00	0	37.06
37.07	ADULTS & PEDIATRICS-OTHER REVEUNUE	B	-9	ADULTS & PEDIATRICS	30.00	0	37.07
37.08	OPERATING ROOM-OTHER REVEUNUE	B	-500	OPERATING ROOM	50.00	0	37.08
37.09	ANESTHESIOLOGY-OTHER REVEUNUE	B	-4	ANESTHESIOLOGY	53.00	0	37.09
37.10	LABORATORY-OTHER REVEUNUE	B	-631	LABORATORY	60.00	0	37.10
37.11	PHYSICAL THERAPY-OTHER REVEUNUE	B	-3,036	PHYSICAL THERAPY	66.00	0	37.11
37.12	RURAL HEALTH CLINIC-OTHER REVEUNUE	B	-34,761	RURAL HEALTH CLINIC	88.00	0	37.12
37.13	RURAL HEALTH CLINIC III-OTHER REVEUN	B	-120	RURAL HEALTH CLINIC III	88.02	0	37.13
37.14	RURAL HEALTH CLINIC IV-OTHER REVEUNU	B	520	RURAL HEALTH CLINIC IV	88.03	0	37.14
37.15	RURAL HEALTH CLINIC V-OTHER REVEUNUE	B	-620	RURAL HEALTH CLINIC V	88.04	0	37.15
37.16	CHEMO/PAIN-OTHER REVEUNUE	B	-37,346	CHEMO/PAIN	90.01	0	37.16
37.17	SENIOR CARE-OTHER REVEUNUE	B	-7	SENIOR CARE	90.02	0	37.17
37.18	SLEEP LAB-OTHER REVEUNUE	B	-342	SLEEP LAB	90.03	0	37.18
37.19	ORTHOPEDICS-OTHER REVEUNUE	B	-5	ORTHOPEDICS	90.04	0	37.19
37.20	EMERGENCY-OTHER REVEUNUE	B	-102	EMERGENCY	91.00	0	37.20
37.21	AMBULANCE SERVICES-OTHER REVEUNUE	B	-681	AMBULANCE SERVICES	95.00	0	37.21
37.22	LOBBYING DUES	A	-13,712	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	37.22
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,674,693				50.00

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

(2) Basis for adjustment (see instructions).

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/6/2021 2:05 pm

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

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/6/2021 2:05 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	615,074	613,228	1,846	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	623,481	623,481	0	0	0	2.00
3.00	60.00	LABORATORY	70,000	0	70,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	20,492	0	20,492	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	71,680	59,680	12,000	0	0	5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	1,482	1,482	0	0	0	6.00
7.00	90.00	CLINIC	9,000	0	9,000	0	0	7.00
8.00	90.01	CHEMO/PAIN	208,290	190,444	17,846	0	0	8.00
9.00	90.02	SENIOR CARE	35,250	0	35,250	0	0	9.00
10.00	90.03	SLEEP LAB	28,934	22,934	6,000	0	0	10.00
11.00	90.04	ORTHOPEDICS	1,131,794	1,131,794	0	0	0	11.00
12.00	90.05	BEHAVIORAL HEALTH CLINIC	52,500	52,500	0	0	0	12.00
13.00	91.00	EMERGENCY	2,177,842	1,351,711	826,131	0	0	13.00
200.00			5,045,819	4,047,254	998,565		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	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	90.05	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	613,228		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	623,481		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	59,680		5.00
6.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	1,482		6.00
7.00	90.00	CLINIC	0	0	0	0		7.00
8.00	90.01	CHEMO/PAIN	0	0	0	190,444		8.00
9.00	90.02	SENIOR CARE	0	0	0	0		9.00
10.00	90.03	SLEEP LAB	0	0	0	22,934		10.00
11.00	90.04	ORTHOPEDICS	0	0	0	1,131,794		11.00
12.00	90.05	BEHAVIORAL HEALTH CLINIC	0	0	0	52,500		12.00
13.00	91.00	EMERGENCY	0	0	0	1,351,711		13.00
200.00			0	0	0	4,047,254		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	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	2,183,295	2,183,295			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,792,827		1,792,827		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,138,849	14,642	12,024	2,165,515	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	10,620,089	322,749	265,027	424,832	5.01
5.02	00560	ADMITTING	2,432,809	51,967	42,673	118,673	5.02
7.00	00700	OPERATION OF PLANT	1,606,598	187,350	153,844	55,026	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,648	15,337	12,594	0	8.00
9.00	00900	HOUSEKEEPING	948,661	10,788	8,859	46,965	9.00
10.00	01000	DIETARY	221,334	48,460	39,794	13,338	10.00
11.00	01100	CAFETERIA	527,643	22,050	18,107	31,829	11.00
13.00	01300	NURSING ADMINISTRATION	453,393	21,798	17,899	36,951	13.00
15.00	01500	PHARMACY	497,282	13,758	11,297	28,205	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	573,663	35,240	28,937	43,865	16.00
17.00	01700	SOCIAL SERVICE	106,950	2,464	2,023	8,994	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,652,826	221,231	181,665	285,706	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,270,987	222,258	182,508	133,498	50.00
53.00	05300	ANESTHESIOLOGY	537,068	1,880	1,543	45,504	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,743,161	116,334	95,528	138,319	54.00
60.00	06000	LABORATORY	1,982,110	48,476	39,807	72,460	60.00
65.00	06500	RESPIRATORY THERAPY	704,691	6,018	4,942	51,454	65.00
66.00	06600	PHYSICAL THERAPY	1,434,162	369,725	303,602	114,500	66.00
69.00	06900	ELECTROCARDIOLOGY	77,088	8,277	6,797	5,501	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,689,681	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	824,848	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,850,618	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,462,441	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	534,634	23,693	19,456	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	668,590	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,928,388	172,218	141,418	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	476,971	25,131	20,636	0	88.04
90.00	09000	CLINIC	167,394	9,714	7,977	12,455	90.00
90.01	04951	CHEMO/PAIN	1,036,303	24,388	20,027	80,085	90.01
90.02	09002	SENIOR CARE	501,128	0	0	640	90.02
90.03	09003	SLEEP LAB	107,357	2,053	1,686	6,627	90.03
90.04	09001	ORTHOPEDICS	343,735	29,111	23,905	119,262	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	288,661	6,760	5,551	8,050	90.05
91.00	09100	EMERGENCY	2,436,843	81,410	66,850	168,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,565,410	0	0	113,904	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,486,136	2,115,280	1,736,976	2,165,515	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	149,009	33,565	27,562	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	414,011	34,450	28,289	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		TOTAL (sum lines 118 through 201)	62,049,156	2,183,295	1,792,827	2,165,515	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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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	11,632,697					5.01
5.02	00560	ADMITTING	610,545	3,256,667				5.02
7.00	00700	OPERATION OF PLANT	462,114	0	2,464,932			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,975	0	27,286	181,840		8.00
9.00	00900	HOUSEKEEPING	234,256	0	19,193	0	1,268,722	9.00
10.00	01000	DIETARY	74,509	0	86,213	0	45,227	10.00
11.00	01100	CAFETERIA	138,354	0	39,228	0	20,579	11.00
13.00	01300	NURSING ADMINISTRATION	122,297	0	38,779	0	20,343	13.00
15.00	01500	PHARMACY	127,028	0	24,476	0	12,840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	157,291	0	62,693	0	32,889	16.00
17.00	01700	SOCIAL SERVICE	27,787	0	4,384	0	2,300	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	770,974	435,805	393,578	181,840	206,471	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	417,452	270,126	395,404	0	207,429	50.00
53.00	05300	ANESTHESIOLOGY	135,208	0	3,344	0	1,754	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	483,001	307,618	206,961	0	108,572	54.00
60.00	06000	LABORATORY	494,425	312,449	86,241	0	45,242	60.00
65.00	06500	RESPIRATORY THERAPY	176,996	111,445	10,706	0	5,617	65.00
66.00	06600	PHYSICAL THERAPY	512,684	335,154	657,751	0	345,058	66.00
69.00	06900	ELECTROCARDIOLOGY	22,534	14,452	14,725	0	7,725	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	620,595	390,088	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	190,319	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	426,997	268,398	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,414,029	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	133,313	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	154,265	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	748,039	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	120,612	0	0	0	0	88.04
90.00	09000	CLINIC	45,579	28,985	17,282	0	9,066	90.00
90.01	04951	CHEMO/PAIN	267,834	169,175	43,387	0	22,761	90.01
90.02	09002	SENIOR CARE	115,774	72,772	0	0	0	90.02
90.03	09003	SLEEP LAB	27,162	17,143	3,653	0	1,916	90.03
90.04	09001	ORTHOPEDICS	119,061	75,810	51,789	0	27,169	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	71,301	45,051	12,027	0	6,309	90.05
91.00	09100	EMERGENCY	635,430	402,196	144,831	0	75,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	387,471	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)	11,474,211	3,256,667	2,343,931	181,840	1,205,245	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,485	0	59,714	0	31,326	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	110,001	0	61,287	0	32,151	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)	11,632,697	3,256,667	2,464,932	181,840	1,268,722	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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7/6/2021 2:05 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	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	528,875					10.00
11.00	01100	CAFETERIA	0	797,790				11.00
13.00	01300	NURSING ADMINISTRATION	0	19,988	731,448			13.00
15.00	01500	PHARMACY	0	15,257	0	730,143		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,728	0	0	958,306	16.00
17.00	01700	SOCIAL SERVICE	0	4,865	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	528,875	154,541	286,422	0	29,570	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	72,214	138,121	0	106,540	50.00
53.00	05300	ANESTHESIOLOGY	0	24,614	0	0	15,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74,821	0	0	256,706	54.00
60.00	06000	LABORATORY	0	39,196	0	0	182,643	60.00
65.00	06500	RESPIRATORY THERAPY	0	27,833	0	0	7,780	65.00
66.00	06600	PHYSICAL THERAPY	0	61,937	0	0	91,588	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,976	0	0	17,149	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	94	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	42,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	12,363	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	730,143	95,025	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	6,737	0	0	1,256	90.00
90.01	04951	CHEMO/PAIN	0	43,321	65,628	0	12,559	90.01
90.02	09002	SENIOR CARE	0	346	681	0	4,064	90.02
90.03	09003	SLEEP LAB	0	3,585	0	0	2,593	90.03
90.04	09001	ORTHOPEDICS	0	64,513	0	0	5,527	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	4,355	0	0	1,437	90.05
91.00	09100	EMERGENCY	0	91,348	119,535	0	73,331	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	61,615	121,061	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	528,875	797,790	731,448	730,143	958,306	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)	528,875	797,790	731,448	730,143	958,306	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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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	159,767				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	159,767	6,489,271	0	6,489,271	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,416,537	0	3,416,537	50.00
53.00	05300	ANESTHESIOLOGY	0	766,628	0	766,628	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,531,021	0	3,531,021	54.00
60.00	06000	LABORATORY	0	3,303,049	0	3,303,049	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,107,482	0	1,107,482	65.00
66.00	06600	PHYSICAL THERAPY	0	4,226,161	0	4,226,161	66.00
69.00	06900	ELECTROCARDIOLOGY	0	177,224	0	177,224	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	94	0	94	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,742,732	0	3,742,732	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,027,530	0	1,027,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,371,181	0	3,371,181	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	12,876,470	0	12,876,470	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	711,096	0	711,096	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	822,855	0	822,855	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,990,063	0	3,990,063	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	643,350	0	643,350	88.04
90.00	09000	CLINIC	0	306,445	0	306,445	90.00
90.01	04951	CHEMO/PAIN	0	1,785,468	0	1,785,468	90.01
90.02	09002	SENIOR CARE	0	695,405	0	695,405	90.02
90.03	09003	SLEEP LAB	0	173,775	0	173,775	90.03
90.04	09001	ORTHOPEDICS	0	859,882	0	859,882	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	449,502	0	449,502	90.05
91.00	09100	EMERGENCY	0	4,296,624	0	4,296,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,249,461	0	2,249,461	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,767	61,019,306	0	61,019,306	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	349,661	0	349,661	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	680,189	0	680,189	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	0	0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	159,767	62,049,156	0	62,049,156	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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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	14,642	12,024	26,666	4.00
5.01	00500	OTHER ADMINISTRATIVE AND GENERAL	0	322,749	265,027	587,776	5.01
5.02	00560	ADMITTING	0	51,967	42,673	94,640	5.02
7.00	00700	OPERATION OF PLANT	0	187,350	153,844	341,194	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,337	12,594	27,931	8.00
9.00	00900	HOUSEKEEPING	0	10,788	8,859	19,647	9.00
10.00	01000	DIETARY	0	48,460	39,794	88,254	10.00
11.00	01100	CAFETERIA	0	22,050	18,107	40,157	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,798	17,899	39,697	13.00
15.00	01500	PHARMACY	0	13,758	11,297	25,055	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,240	28,937	64,177	16.00
17.00	01700	SOCIAL SERVICE	0	2,464	2,023	4,487	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	221,231	181,665	402,896	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	222,258	182,508	404,766	50.00
53.00	05300	ANESTHESIOLOGY	0	1,880	1,543	3,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	116,334	95,528	211,862	54.00
60.00	06000	LABORATORY	0	48,476	39,807	88,283	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,018	4,942	10,960	65.00
66.00	06600	PHYSICAL THERAPY	0	369,725	303,602	673,327	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,277	6,797	15,074	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	23,693	19,456	43,149	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	172,218	141,418	313,636	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	25,131	20,636	45,767	88.04
90.00	09000	CLINIC	0	9,714	7,977	17,691	90.00
90.01	04951	CHEMO/PAIN	0	24,388	20,027	44,415	90.01
90.02	09002	SENIOR CARE	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	2,053	1,686	3,739	90.03
90.04	09001	ORTHOPEDICS	0	29,111	23,905	53,016	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	6,760	5,551	12,311	90.05
91.00	09100	EMERGENCY	0	81,410	66,850	148,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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	2,115,280	1,736,976	3,852,256	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,565	27,562	61,127	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	34,450	28,289	62,739	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		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,183,295	1,792,827	3,976,122	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/6/2021 2:05 pm

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	593,008				5.01
5.02	00560	ADMITTING	31,124	127,225			5.02
7.00	00700	OPERATION OF PLANT	23,557	0	365,429		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,477	0	4,045	33,453	8.00
9.00	00900	HOUSEKEEPING	11,942	0	2,845	0	9.00
10.00	01000	DIETARY	3,798	0	12,781	0	10.00
11.00	01100	CAFETERIA	7,053	0	5,816	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,234	0	5,749	0	13.00
15.00	01500	PHARMACY	6,475	0	3,629	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,018	0	9,294	0	16.00
17.00	01700	SOCIAL SERVICE	1,417	0	650	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,302	17,026	58,348	33,453	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,280	10,552	58,619	0	50.00
53.00	05300	ANESTHESIOLOGY	6,892	0	496	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,622	12,017	30,682	0	54.00
60.00	06000	LABORATORY	25,204	12,206	12,785	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,023	4,354	1,587	0	65.00
66.00	06600	PHYSICAL THERAPY	26,135	13,093	97,513	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,149	565	2,183	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,636	15,239	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,702	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,767	10,485	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	123,069	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,796	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,864	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	38,133	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	6,148	0	0	0	88.04
90.00	09000	CLINIC	2,323	1,132	2,562	0	90.00
90.01	04951	CHEMO/PAIN	13,653	6,609	6,432	0	90.01
90.02	09002	SENIOR CARE	5,902	2,843	0	0	90.02
90.03	09003	SLEEP LAB	1,385	670	542	0	90.03
90.04	09001	ORTHOPEDICS	6,069	2,962	7,678	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	3,635	1,760	1,783	0	90.05
91.00	09100	EMERGENCY	32,392	15,712	21,471	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				2,097	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	19,752	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)	584,928	127,225	347,490	33,453	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,472	0	8,853	0	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	5,608	0	9,086	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	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	593,008	127,225	365,429	33,453	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	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	106,245					10.00
11.00	01100	CAFETERIA	0	53,986				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,353	54,049			13.00
15.00	01500	PHARMACY	0	1,032	0	36,892		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,606	0	0	84,543	16.00
17.00	01700	SOCIAL SERVICE	0	329	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	106,245	10,461	21,167	0	2,608	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,886	10,206	0	9,395	50.00
53.00	05300	ANESTHESIOLOGY	0	1,666	0	0	1,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,063	0	0	22,672	54.00
60.00	06000	LABORATORY	0	2,652	0	0	16,106	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,883	0	0	686	65.00
66.00	06600	PHYSICAL THERAPY	0	4,191	0	0	8,077	66.00
69.00	06900	ELECTROCARDIOLOGY	0	201	0	0	1,512	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,736	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,090	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,892	8,380	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	456	0	0	111	90.00
90.01	04951	CHEMO/PAIN	0	2,931	4,849	0	1,108	90.01
90.02	09002	SENIOR CARE	0	23	50	0	358	90.02
90.03	09003	SLEEP LAB	0	243	0	0	229	90.03
90.04	09001	ORTHOPEDICS	0	4,365	0	0	487	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	295	0	0	127	90.05
91.00	09100	EMERGENCY	0	6,181	8,832	0	6,467	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	4,169	8,945	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,245	53,986	54,049	36,892	84,543	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)	106,245	53,986	54,049	36,892	84,543	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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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	7,057				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,057	707,779	0	707,779	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	527,072	0	527,072	50.00
53.00	05300	ANESTHESIOLOGY	0	14,471	0	14,471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	311,617	0	311,617	54.00
60.00	06000	LABORATORY	0	159,377	0	159,377	60.00
65.00	06500	RESPIRATORY THERAPY	0	29,282	0	29,282	65.00
66.00	06600	PHYSICAL THERAPY	0	833,270	0	833,270	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,965	0	20,965	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8	0	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	50,611	0	50,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,792	0	10,792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	77,524	0	77,524	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	123,069	0	123,069	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	49,945	0	49,945	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	7,864	0	7,864	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	351,769	0	351,769	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	51,915	0	51,915	88.04
90.00	09000	CLINIC	0	24,678	0	24,678	90.00
90.01	04951	CHEMO/PAIN	0	81,611	0	81,611	90.01
90.02	09002	SENIOR CARE	0	9,184	0	9,184	90.02
90.03	09003	SLEEP LAB	0	6,943	0	6,943	90.03
90.04	09001	ORTHOPEDICS	0	76,796	0	76,796	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	20,184	0	20,184	90.05
91.00	09100	EMERGENCY	0	243,491	0	243,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	34,269	0	34,269	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,057	3,824,486	0	3,824,486	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	73,316	0	73,316	192.00
192.01	19202	BEHAVIORAL HEALTH CLINIC	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	78,320	0	78,320	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	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,057	3,976,122	0	3,976,122	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/6/2021 2:05 pm

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	138,223				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		138,223			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	927	927	23,618,751		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	20,433	20,433	4,633,511	-11,632,697	5.01
5.02	00560	ADMITTING	3,290	3,290	1,294,344	0	5.02
7.00	00700	OPERATION OF PLANT	11,861	11,861	600,161	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	8.00
9.00	00900	HOUSEKEEPING	683	683	512,235	0	9.00
10.00	01000	DIETARY	3,068	3,068	145,472	0	10.00
11.00	01100	CAFETERIA	1,396	1,396	347,151	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,380	1,380	403,012	0	13.00
15.00	01500	PHARMACY	871	871	307,628	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	478,423	0	16.00
17.00	01700	SOCIAL SERVICE	156	156	98,091	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,006	14,006	3,116,131	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,071	14,071	1,456,036	0	50.00
53.00	05300	ANESTHESIOLOGY	119	119	496,299	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,365	7,365	1,508,611	0	54.00
60.00	06000	LABORATORY	3,069	3,069	790,309	0	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	561,196	0	65.00
66.00	06600	PHYSICAL THERAPY	23,407	23,407	1,248,825	0	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	60,000	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	1,500	1,500	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	10,903	10,903	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,591	1,591	0	0	88.04
90.00	09000	CLINIC	615	615	135,843	0	90.00
90.01	04951	CHEMO/PAIN	1,544	1,544	873,470	0	90.01
90.02	09002	SENIOR CARE	0	0	6,983	0	90.02
90.03	09003	SLEEP LAB	130	130	72,275	0	90.03
90.04	09001	ORTHOPEDICS	1,843	1,843	1,300,761	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	428	428	87,803	0	90.05
91.00	09100	EMERGENCY	5,154	5,154	1,841,849	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	1,242,332	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,917	133,917	23,618,751	-11,632,697	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	2,181	2,181	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)	2,183,295	1,792,827	2,165,515	11,632,697	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.795454	12.970540	0.091686	0.230732	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			26,666	593,008	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001129	0.011762	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 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		ADMITTING (ACCUM. 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	26,682,361				5.02
7.00	00700	OPERATION OF PLANT	0	87,718			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100		8.00
9.00	00900	HOUSEKEEPING	0	683	0	86,064	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	3,570,593	14,006	100	14,006	100 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,213,182	14,071	0	14,071	0 50.00
53.00	05300	ANESTHESIOLOGY	0	119	0	119	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,520,361	7,365	0	7,365	0 54.00
60.00	06000	LABORATORY	2,559,948	3,069	0	3,069	0 60.00
65.00	06500	RESPIRATORY THERAPY	913,085	381	0	381	0 65.00
66.00	06600	PHYSICAL THERAPY	2,745,975	23,407	0	23,407	0 66.00
69.00	06900	ELECTROCARDIOLOGY	118,405	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	3,196,056	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	2,199,026	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	237,476	615	0	615	0 90.00
90.01	04951	CHEMO/PAIN	1,386,078	1,544	0	1,544	0 90.01
90.02	09002	SENIOR CARE	596,231	0	0	0	0 90.02
90.03	09003	SLEEP LAB	140,455	130	0	130	0 90.03
90.04	09001	ORTHOPEDICS	621,122	1,843	0	1,843	0 90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	369,113	428	0	428	0 90.05
91.00	09100	EMERGENCY	3,295,255	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)	26,682,361	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	2,181	0	2,181	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)	3,256,667	2,464,932	181,840	1,268,722	528,875 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.122053	28.100641	1,818.400000	14.741611	5,288.750000 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	127,225	365,429	33,453	35,012	106,245 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004768	4.165952	334.530000	0.406814	1,062.450000 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 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (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	16,085,877					11.00
13.00	01300	NURSING ADMINISTRATION	403,012	7,505,388				13.00
15.00	01500	PHARMACY	307,628	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	478,423	0	0	97,356,251		16.00
17.00	01700	SOCIAL SERVICE	98,091	0	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,116,131	2,938,954	0	3,004,155	100	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,456,036	1,417,261	0	10,823,935	0	50.00
53.00	05300	ANESTHESIOLOGY	496,299	0	0	1,596,337	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,508,611	0	0	26,077,293	0	54.00
60.00	06000	LABORATORY	790,309	0	0	18,555,581	0	60.00
65.00	06500	RESPIRATORY THERAPY	561,196	0	0	790,432	0	65.00
66.00	06600	PHYSICAL THERAPY	1,248,825	0	0	9,304,836	0	66.00
69.00	06900	ELECTROCARDIOLOGY	60,000	0	0	1,742,212	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	9,591	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,304,406	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,255,972	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	9,654,108	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	135,843	0	0	127,617	0	90.00
90.01	04951	CHEMO/PAIN	873,470	673,416	0	1,275,981	0	90.01
90.02	09002	SENIOR CARE	6,983	6,983	0	412,859	0	90.02
90.03	09003	SLEEP LAB	72,275	0	0	263,456	0	90.03
90.04	09001	ORTHOPEDICS	1,300,761	0	0	561,498	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	87,803	0	0	145,949	0	90.05
91.00	09100	EMERGENCY	1,841,849	1,226,557	0	7,450,033	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,242,332	1,242,217	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)	16,085,877	7,505,388	100	97,356,251	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)	797,790	731,448	730,143	958,306	159,767	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.049596	0.097456	7,301.430000	0.009843	1,597.670000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,986	54,049	36,892	84,543	7,057	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003356	0.007201	368.920000	0.000868	70.570000	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 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,489,271		6,489,271	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,416,537		3,416,537	0	0	50.00
53.00	05300	ANESTHESIOLOGY	766,628		766,628	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,531,021		3,531,021	0	0	54.00
60.00	06000	LABORATORY	3,303,049		3,303,049	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,107,482	0	1,107,482	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,226,161	0	4,226,161	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	177,224		177,224	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94		94	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,742,732		3,742,732	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,027,530		1,027,530	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,371,181		3,371,181	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	12,876,470		12,876,470	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	711,096		711,096	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	822,855		822,855	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,990,063		3,990,063	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	643,350		643,350	0	0	88.04
90.00	09000	CLINIC	306,445		306,445	0	0	90.00
90.01	04951	CHEMO/PAIN	1,785,468		1,785,468	0	0	90.01
90.02	09002	SENIOR CARE	695,405		695,405	0	0	90.02
90.03	09003	SLEEP LAB	173,775		173,775	0	0	90.03
90.04	09001	ORTHOPEDICS	859,882		859,882	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	449,502		449,502	0	0	90.05
91.00	09100	EMERGENCY	4,296,624		4,296,624	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,865,577		1,865,577	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,249,461		2,249,461	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	62,884,883	0	62,884,883	0	0	200.00
201.00		Less Observation Beds	1,865,577		1,865,577			201.00
202.00		Total (see instructions)	61,019,306	0	61,019,306	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,149,518		2,149,518		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,177,733	9,646,202	10,823,935	0.315646	50.00
53.00	05300	ANESTHESIOLOGY	213,102	1,383,235	1,596,337	0.480242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,208	25,383,085	26,077,293	0.135406	54.00
60.00	06000	LABORATORY	1,313,943	17,241,638	18,555,581	0.178008	60.00
65.00	06500	RESPIRATORY THERAPY	298,903	491,529	790,432	1.401110	65.00
66.00	06600	PHYSICAL THERAPY	885,117	8,419,719	9,304,836	0.454190	66.00
69.00	06900	ELECTROCARDIOLOGY	28,270	1,713,942	1,742,212	0.101724	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,591	9,591	0.009801	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	800,959	3,503,447	4,304,406	0.869512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	526,200	729,772	1,255,972	0.818115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,581,504	8,072,604	9,654,108	0.349197	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	10,808,907	10,808,907		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	590,879	590,879		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	444,319	444,319		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,904,283	2,904,283		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,156,410	1,156,410		88.04
90.00	09000	CLINIC	0	127,617	127,617	2.401287	90.00
90.01	04951	CHEMO/PAIN	0	1,275,981	1,275,981	1.399290	90.01
90.02	09002	SENIOR CARE	0	412,859	412,859	1.684364	90.02
90.03	09003	SLEEP LAB	0	263,456	263,456	0.659598	90.03
90.04	09001	ORTHOPEDICS	0	561,498	561,498	1.531407	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	145,949	145,949	3.079857	90.05
91.00	09100	EMERGENCY	4,637	7,445,396	7,450,033	0.576725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,233	849,404	854,637	2.182888	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,129,415	2,129,415	1.056375	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	9,679,327	105,711,137	115,390,464		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,679,327	105,711,137	115,390,464		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
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 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

			Title XIX	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	6,489,271		6,489,271	0	6,489,271 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,416,537		3,416,537	0	3,416,537 50.00
53.00	05300 ANESTHESIOLOGY	766,628		766,628	0	766,628 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,531,021		3,531,021	0	3,531,021 54.00
60.00	06000 LABORATORY	3,303,049		3,303,049	0	3,303,049 60.00
65.00	06500 RESPIRATORY THERAPY	1,107,482	0	1,107,482	0	1,107,482 65.00
66.00	06600 PHYSICAL THERAPY	4,226,161	0	4,226,161	0	4,226,161 66.00
69.00	06900 ELECTROCARDIOLOGY	177,224		177,224	0	177,224 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	94		94	0	94 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,742,732		3,742,732	0	3,742,732 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,027,530		1,027,530	0	1,027,530 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,371,181		3,371,181	0	3,371,181 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	12,876,470		12,876,470	0	12,876,470 88.00
88.01	08801 RURAL HEALTH CLINIC II	711,096		711,096	0	711,096 88.01
88.02	08802 RURAL HEALTH CLINIC III	822,855		822,855	0	822,855 88.02
88.03	08803 RURAL HEALTH CLINIC IV	3,990,063		3,990,063	0	3,990,063 88.03
88.04	08804 RURAL HEALTH CLINIC V	643,350		643,350	0	643,350 88.04
90.00	09000 CLINIC	306,445		306,445	0	306,445 90.00
90.01	04951 CHEMO/PAIN	1,785,468		1,785,468	0	1,785,468 90.01
90.02	09002 SENIOR CARE	695,405		695,405	0	695,405 90.02
90.03	09003 SLEEP LAB	173,775		173,775	0	173,775 90.03
90.04	09001 ORTHOPEDICS	859,882		859,882	0	859,882 90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	449,502		449,502	0	449,502 90.05
91.00	09100 EMERGENCY	4,296,624		4,296,624	0	4,296,624 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,865,577		1,865,577	0	1,865,577 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2,249,461		2,249,461	0	2,249,461 95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	62,884,883	0	62,884,883	0	62,884,883 200.00
201.00	Less Observation Beds	1,865,577		1,865,577		1,865,577 201.00
202.00	Total (see instructions)	61,019,306	0	61,019,306	0	61,019,306 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

			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	2,149,518		2,149,518		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,177,733	9,646,202	10,823,935	0.315646	50.00
53.00	05300	ANESTHESIOLOGY	213,102	1,383,235	1,596,337	0.480242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,208	25,383,085	26,077,293	0.135406	54.00
60.00	06000	LABORATORY	1,313,943	17,241,638	18,555,581	0.178008	60.00
65.00	06500	RESPIRATORY THERAPY	298,903	491,529	790,432	1.401110	65.00
66.00	06600	PHYSICAL THERAPY	885,117	8,419,719	9,304,836	0.454190	66.00
69.00	06900	ELECTROCARDIOLOGY	28,270	1,713,942	1,742,212	0.101724	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,591	9,591	0.009801	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	800,959	3,503,447	4,304,406	0.869512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	526,200	729,772	1,255,972	0.818115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,581,504	8,072,604	9,654,108	0.349197	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	10,808,907	10,808,907	1.191283	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	590,879	590,879	1.203455	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	444,319	444,319	1.851946	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,904,283	2,904,283	1.373855	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,156,410	1,156,410	0.556334	88.04
90.00	09000	CLINIC	0	127,617	127,617	2.401287	90.00
90.01	04951	CHEMO/PAIN	0	1,275,981	1,275,981	1.399290	90.01
90.02	09002	SENIOR CARE	0	412,859	412,859	1.684364	90.02
90.03	09003	SLEEP LAB	0	263,456	263,456	0.659598	90.03
90.04	09001	ORTHOPEDICS	0	561,498	561,498	1.531407	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	145,949	145,949	3.079857	90.05
91.00	09100	EMERGENCY	4,637	7,445,396	7,450,033	0.576725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,233	849,404	854,637	2.182888	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,129,415	2,129,415	1.056375	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	9,679,327	105,711,137	115,390,464		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,679,327	105,711,137	115,390,464		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

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 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description			Title XVIII		Hospital	Cost		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	527,072	10,823,935	0.048695	597,190	29,080	50.00
53.00	05300	ANESTHESIOLOGY	14,471	1,596,337	0.009065	112,163	1,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	311,617	26,077,293	0.011950	439,333	5,250	54.00
60.00	06000	LABORATORY	159,377	18,555,581	0.008589	774,593	6,653	60.00
65.00	06500	RESPIRATORY THERAPY	29,282	790,432	0.037046	168,151	6,229	65.00
66.00	06600	PHYSICAL THERAPY	833,270	9,304,836	0.089552	257,295	23,041	66.00
69.00	06900	ELECTROCARDIOLOGY	20,965	1,742,212	0.012034	19,317	232	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8	9,591	0.000834	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,611	4,304,406	0.011758	387,022	4,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,792	1,255,972	0.008593	254,207	2,184	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,524	9,654,108	0.008030	774,360	6,218	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	123,069	10,808,907	0.011386	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	49,945	590,879	0.084527	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,864	444,319	0.017699	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	351,769	2,904,283	0.121121	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	51,915	1,156,410	0.044893	0	0	88.04
90.00	09000	CLINIC	24,678	127,617	0.193375	0	0	90.00
90.01	04951	CHEMO/PAIN	81,611	1,275,981	0.063959	0	0	90.01
90.02	09002	SENIOR CARE	9,184	412,859	0.022245	0	0	90.02
90.03	09003	SLEEP LAB	6,943	263,456	0.026354	0	0	90.03
90.04	09001	ORTHOPEDICS	76,796	561,498	0.136770	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	20,184	145,949	0.138295	0	0	90.05
91.00	09100	EMERGENCY	243,491	7,450,033	0.032683	3,473	114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	203,477	854,637	0.238086	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,285,915	111,111,531		3,787,104	84,569	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/6/2021 2:05 pm

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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	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	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	10,823,935	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	1,596,337	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,077,293	0.000000
60.00	06000	LABORATORY	0	0	0	18,555,581	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	790,432	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	9,304,836	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,742,212	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	9,591	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,304,406	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,255,972	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,654,108	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	10,808,907	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	590,879	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	444,319	0.000000
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	2,904,283	0.000000
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,156,410	0.000000
90.00	09000	CLINIC	0	0	0	127,617	0.000000
90.01	04951	CHEMO/PAIN	0	0	0	1,275,981	0.000000
90.02	09002	SENIOR CARE	0	0	0	412,859	0.000000
90.03	09003	SLEEP LAB	0	0	0	263,456	0.000000
90.04	09001	ORTHOPEDICS	0	0	0	561,498	0.000000
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	145,949	0.000000
91.00	09100	EMERGENCY	0	0	0	7,450,033	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	854,637	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	0	0	0	111,111,531	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	597,190	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	112,163	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	439,333	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	774,593	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	168,151	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	257,295	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	19,317	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	387,022	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	254,207	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	774,360	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	0	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	3,473	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)		3,787,104	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/6/2021 2:05 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.315646	0	2,758,777	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.480242	0	360,899	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135406	0	8,134,040	0	0	54.00
60.00	06000	LABORATORY	0.178008	0	5,528,934	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.401110	0	179,634	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.454190	0	2,623,417	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.101724	0	625,793	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.009801	0	6,074	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.869512	0	1,143,436	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.818115	0	213,261	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349197	0	3,121,540	217	0	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	2.401287	0	78,528	0	0	90.00
90.01	04951	CHEMO/PAIN	1.399290	0	376,129	40	0	90.01
90.02	09002	SENIOR CARE	1.684364	0	384,735	0	0	90.02
90.03	09003	SLEEP LAB	0.659598	0	88,877	0	0	90.03
90.04	09001	ORTHOPEDICS	1.531407	0	172,994	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	3.079857	0	43,477	0	0	90.05
91.00	09100	EMERGENCY	0.576725	0	1,958,442	376	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.182888	0	385,606	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1.056375		0			95.00
200.00		Subtotal (see instructions)		0	28,184,593	633	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	28,184,593	633	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/6/2021 2:05 pm

			Title XVIII	Hospital	Cost
	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	870,797	0	50.00
53.00	05300	ANESTHESIOLOGY	173,319	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,101,398	0	54.00
60.00	06000	LABORATORY	984,194	0	60.00
65.00	06500	RESPIRATORY THERAPY	251,687	0	65.00
66.00	06600	PHYSICAL THERAPY	1,191,530	0	66.00
69.00	06900	ELECTROCARDIOLOGY	63,658	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	60	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	994,231	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	174,472	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,090,032	76	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	188,568	0	90.00
90.01	04951	CHEMO/PAIN	526,314	56	90.01
90.02	09002	SENIOR CARE	648,034	0	90.02
90.03	09003	SLEEP LAB	58,623	0	90.03
90.04	09001	ORTHOPEDICS	264,924	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	133,903	0	90.05
91.00	09100	EMERGENCY	1,129,482	217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	841,735	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	10,686,961	349	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	10,686,961	349	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/6/2021 2:05 pm

			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	0.315646	0	0	213,355	0	50.00
53.00	05300	ANESTHESIOLOGY	0.480242	0	0	43,616	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135406	0	0	624,354	0	54.00
60.00	06000	LABORATORY	0.178008	0	0	233,967	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.401110	0	0	8,709	0	65.00
66.00	06600	PHYSICAL THERAPY	0.454190	0	0	44,311	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.101724	0	0	45,915	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.009801	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.869512	0	0	139,729	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.818115	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349197	0	0	108,524	0	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	2.401287	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	1.399290	0	0	19,242	0	90.01
90.02	09002	SENIOR CARE	1.684364	0	0	47	0	90.02
90.03	09003	SLEEP LAB	0.659598	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	1.531407	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	3.079857	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.576725	0	0	179,476	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.182888	0	0	2,905	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1.056375	0	0			95.00
200.00		Subtotal (see instructions)		0	0	1,664,150	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	1,664,150	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/6/2021 2:05 pm

				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	67,345		50.00
53.00	05300	ANESTHESIOLOGY	0	20,946		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,541		54.00
60.00	06000	LABORATORY	0	41,648		60.00
65.00	06500	RESPIRATORY THERAPY	0	12,202		65.00
66.00	06600	PHYSICAL THERAPY	0	20,126		66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,671		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	121,496		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,896		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	0		90.00
90.01	04951	CHEMO/PAIN	0	26,925		90.01
90.02	09002	SENIOR CARE	0	79		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	103,508		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,341		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	547,724		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	547,724		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/6/2021 2:05 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,051	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,685	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)			1,653	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			885	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			238	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,134	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)			647	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)			6,489,271	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)			35,693	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)			1,635,525	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,853,746	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)			4,853,746	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)			1,807.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,049,954	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)			2,049,954	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,611,060	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,661,014	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)					1,169,595	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)					1,169,595	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)					1,032	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,807.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,865,577	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/6/2021 2:05 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	707,779	6,489,271	0.109069	1,865,577	203,477
91.00	Nursing School cost	0	6,489,271	0.000000	1,865,577	0
92.00	Allied health cost	0	6,489,271	0.000000	1,865,577	0
93.00	All other Medical Education	0	6,489,271	0.000000	1,865,577	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/6/2021 2:05 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,070,275		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.315646	597,190	188,501	50.00
53.00	05300 ANESTHESIOLOGY	0.480242	112,163	53,865	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135406	439,333	59,488	54.00
60.00	06000 LABORATORY	0.178008	774,593	137,884	60.00
65.00	06500 RESPIRATORY THERAPY	1.401110	168,151	235,598	65.00
66.00	06600 PHYSICAL THERAPY	0.454190	257,295	116,861	66.00
69.00	06900 ELECTROCARDIOLOGY	0.101724	19,317	1,965	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.009801	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.869512	387,022	336,520	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.818115	254,207	207,971	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.349197	774,360	270,404	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	2.401287	0	0	90.00
90.01	04951 CHEMO/PAIN	1.399290	0	0	90.01
90.02	09002 SENIOR CARE	1.684364	0	0	90.02
90.03	09003 SLEEP LAB	0.659598	0	0	90.03
90.04	09001 ORTHOPEDICS	1.531407	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	3.079857	0	0	90.05
91.00	09100 EMERGENCY	0.576725	3,473	2,003	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.182888	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)		3,787,104	1,611,060	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)		3,787,104		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1320 Component CCN: 14-Z320	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/6/2021 2:05 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.315646	1,625	513	50.00
53.00	05300 ANESTHESIOLOGY	0.480242	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135406	57,491	7,785	54.00
60.00	06000 LABORATORY	0.178008	156,377	27,836	60.00
65.00	06500 RESPIRATORY THERAPY	1.401110	37,934	53,150	65.00
66.00	06600 PHYSICAL THERAPY	0.454190	361,515	164,196	66.00
69.00	06900 ELECTROCARDIOLOGY	0.101724	1,028	105	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.009801	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.869512	37,212	32,356	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.818115	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.349197	224,650	78,447	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	2.401287	0	0	90.00
90.01	04951 CHEMO/PAIN	1.399290	0	0	90.01
90.02	09002 SENIOR CARE	1.684364	0	0	90.02
90.03	09003 SLEEP LAB	0.659598	0	0	90.03
90.04	09001 ORTHOPEDICS	1.531407	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	3.079857	0	0	90.05
91.00	09100 EMERGENCY	0.576725	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.182888	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)		877,832	364,388	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)		877,832		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/6/2021 2:05 pm	
Cost Center Description		Title XIX	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		5,322		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.315646	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.480242	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135406	8,229	1,114	54.00
60.00	06000 LABORATORY	0.178008	8,592	1,529	60.00
65.00	06500 RESPIRATORY THERAPY	1.401110	1,285	1,800	65.00
66.00	06600 PHYSICAL THERAPY	0.454190	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.101724	1,563	159	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.009801	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.869512	735	639	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.818115	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.349197	6,451	2,253	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.191283	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.203455	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	1.851946	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	1.373855	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.556334	0	0	88.04
90.00	09000 CLINIC	2.401287	0	0	90.00
90.01	04951 CHEMO/PAIN	1.399290	0	0	90.01
90.02	09002 SENIOR CARE	1.684364	0	0	90.02
90.03	09003 SLEEP LAB	0.659598	0	0	90.03
90.04	09001 ORTHOPEDICS	1.531407	0	0	90.04
90.05	09004 BEHAVIORAL HEALTH CLINIC	3.079857	0	0	90.05
91.00	09100 EMERGENCY	0.576725	1,164	671	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.182888	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)		28,019	8,165	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)		28,019		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/6/2021 2:05 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,687,310	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)		10,687,310	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)		10,794,183	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)		65,958	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,500,562	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)		6,227,663	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)		6,227,663	30.00
31.00	Primary payer payments		1,775	31.00
32.00	Subtotal (line 30 minus line 31)		6,225,888	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)		296,393	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		192,655	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,067	36.00
37.00	Subtotal (see instructions)		6,418,543	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)		6,418,543	40.00
40.01	Sequestration adjustment (see instructions)		42,362	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		5,656,232	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		719,949	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		103,738	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 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/6/2021 2:05 pm

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,913,235		5,551,826	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	05/13/2020	104,406	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	05/13/2020	71,025		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)		-71,025		104,406	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,842,210		5,656,232	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		489,653		719,949	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,331,863		6,376,181	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 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
7/6/2021 2:05 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,314,476		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	05/13/2020	4,278		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)		4,278		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)		1,318,754		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		206,531		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,525,285		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 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/6/2021 2:05 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1320 Component CCN: 14-Z320	Period: From 01/01/2020 To 12/31/2020	Worksheet E-2 Date/Time Prepared: 7/6/2021 2:05 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,181,291	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	368,032	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	647	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)	1,549,323	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,549,323	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)	1,549,323	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,904	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,535,419	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)	1,535,419	0	19.00
19.01	Sequestration adjustment (see instructions)	10,134	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	1,318,754	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	206,531	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1320	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/6/2021 2:05 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,661,014	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)		3,661,014	4.00
5.00	Primary payer payments		3,994	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,693,630	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)		3,693,630	19.00
20.00	Deductibles (exclude professional component)		351,284	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		3,342,346	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		3,342,346	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		17,928	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		11,653	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)		3,353,999	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)		3,353,999	30.00
30.01	Sequestration adjustment (see instructions)		22,136	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,842,210	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		489,653	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		6,275	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 01/01/2020
To 12/31/2020

Worksheet G

Date/Time Prepared:
7/6/2021 2:05 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	17,393,011	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	25,094,644	0	0	0	4.00
5.00	Other receivable	3,196,390	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,298,608	0	0	0	6.00
7.00	Inventory	1,984,432	0	0	0	7.00
8.00	Prepaid expenses	735,400	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)	33,105,269	0	0	0	11.00
FIXED ASSETS						
12.00	Land	501,832	0	0	0	12.00
13.00	Land improvements	3,139,004	0	0	0	13.00
14.00	Accumulated depreciation	-1,941,974	0	0	0	14.00
15.00	Buildings	49,686,296	0	0	0	15.00
16.00	Accumulated depreciation	-20,492,331	0	0	0	16.00
17.00	Leasehold improvements	1,777,556	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	23,109,558	0	0	0	23.00
24.00	Accumulated depreciation	-16,847,961	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)	38,857,236	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)	71,962,505	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,945,108	0	0	0	37.00
38.00	Salaries, wages, and fees payable	41,199	0	0	0	38.00
39.00	Payroll taxes payable	4,890,532	0	0	0	39.00
40.00	Notes and loans payable (short term)	9,825,117	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	0	0	0	0	43.00
44.00	Other current liabilities	5,730,435	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,432,391	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30,432,391	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	41,530,114				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)	41,530,114	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,962,505	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-1

Date/Time Prepared:
7/6/2021 2:05 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		36,678,105		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,852,009				2.00
3.00	Total (sum of line 1 and line 2)		41,530,114		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)		41,530,114		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)		41,530,114		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 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/6/2021 2:05 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,857,637		4,857,637	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)	4,857,637		4,857,637	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)	4,857,637		4,857,637	17.00
18.00	Ancillary services	6,382,427	106,718,338	113,100,765	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	10,808,907	10,808,907	20.00
20.01	RURAL HEALTH CLINIC II	0	590,879	590,879	20.01
20.02	RURAL HEALTH CLINIC III	0	444,319	444,319	20.02
20.03	RURAL HEALTH CLINIC IV	0	2,904,283	2,904,283	20.03
20.04	RURAL HEALTH CLINIC V	0	1,156,410	1,156,410	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	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,240,064	122,623,136	133,863,200	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		68,723,849		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)		68,723,849		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1320

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-3

Date/Time Prepared:
7/6/2021 2:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	133,863,200	1.00
2.00	Less contractual allowances and discounts on patients' accounts	71,593,970	2.00
3.00	Net patient revenues (line 1 minus line 2)	62,269,230	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	68,723,849	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,454,619	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	443,319	6.00
7.00	Income from investments	87,363	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	14,241	10.00
11.00	Rebates and refunds of expenses	146,168	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	109,896	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	2,856	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	6,444	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	163,446	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	735,109	24.00
24.01	PHARMACY	3,474,478	24.01
24.02	PRO FEES	76,369	24.02
24.50	COVID-19 PHE Funding	6,046,939	24.50
25.00	Total other income (sum of lines 6-24)	11,306,628	25.00
26.00	Total (line 5 plus line 25)	4,852,009	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)	4,852,009	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3987

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,458,071	0	3,458,071	-81,562	3,376,509 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	617,654	0	617,654	-3,999	613,655 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	1,847,899	0	1,847,899	0	1,847,899 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	494,014	0	494,014	0	494,014 9.00
10.00	Subtotal (sum of lines 1 through 9)	6,417,638	0	6,417,638	-85,561	6,332,077 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	32,101	32,101	0	32,101 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	189,306	189,306	0	189,306 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	221,407	221,407	0	221,407 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	6,417,638	221,407	6,639,045	-85,561	6,553,484 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	85,561	85,561 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	85,561	85,561 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	359,045	359,045	0	359,045 29.00
30.00	Administrative Costs	1,484,248	2,107,085	3,591,333	0	3,591,333 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,484,248	2,466,130	3,950,378	0	3,950,378 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	7,901,886	2,687,537	10,589,423	0	10,589,423 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3987

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	3,376,509	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	613,655	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,847,899	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	494,014	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	6,332,077	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	32,101	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	189,306	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	221,407	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	6,553,484	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	85,561	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	85,561	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	359,045	29.00
30.00	Administrative Costs	-126,982	3,464,351	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-126,982	3,823,396	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-126,982	10,462,441	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3989

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		RHC II		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	205,073	0	205,073	-5,063	200,010
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	104,192	0	104,192	0	104,192
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)	309,265	0	309,265	-5,063	304,202
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	11,510	11,510	0	11,510
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	21,847	21,847	0	21,847
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	33,357	33,357	0	33,357
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	309,265	33,357	342,622	-5,063	337,559
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	5,063	5,063
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	5,063	5,063
FACILITY OVERHEAD						
29.00	Facility Costs	0	9,428	9,428	0	9,428
30.00	Administrative Costs	51,567	132,296	183,863	0	183,863
31.00	Total Facility Overhead (sum of lines 29 and 30)	51,567	141,724	193,291	0	193,291
32.00	Total facility costs (sum of lines 22, 28 and 31)	360,832	175,081	535,913	0	535,913

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-3989

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		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	200,010		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	104,192		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	304,202		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	11,510		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	21,847		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	33,357		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	337,559		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	5,063		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	5,063		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	9,428		29.00
30.00	Administrative Costs	-1,279	182,584		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,279	192,012		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,279	534,634		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8596

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		RHC III		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	348,226	0	348,226	0	348,226
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	89,734	0	89,734	-776	88,958
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	49,119	0	49,119	0	49,119
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)	487,079	0	487,079	-776	486,303
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	2,330	2,330	0	2,330
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	6,935	6,935	0	6,935
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	9,265	9,265	0	9,265
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	487,079	9,265	496,344	-776	495,568
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	776	776
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	776	776
FACILITY OVERHEAD					
29.00 Facility Costs	0	7,158	7,158	0	7,158
30.00 Administrative Costs	36,851	128,960	165,811	0	165,811
31.00 Total Facility Overhead (sum of lines 29 and 30)	36,851	136,118	172,969	0	172,969
32.00 Total facility costs (sum of lines 22, 28 and 31)	523,930	145,383	669,313	0	669,313

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8596

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		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	348,226	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	88,958	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	49,119	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	486,303	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	2,330	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	6,935	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	9,265	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	495,568	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	776	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	776	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	7,158	29.00
30.00	Administrative Costs	-723	165,088	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-723	172,246	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-723	668,590	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8607

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

						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	477,985	0	477,985	0	477,985	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	884,198	0	884,198	-274	883,924	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	229,968	0	229,968	0	229,968	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	243,171	0	243,171	0	243,171	9.00		
10.00	Subtotal (sum of lines 1 through 9)	1,835,322	0	1,835,322	-274	1,835,048	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	46,693	46,693	0	46,693	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	20,588	20,588	0	20,588	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	67,281	67,281	0	67,281	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,835,322	67,281	1,902,603	-274	1,902,329	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	274	274	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs	0	0	0	0	0	27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	274	274	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	11,848	11,848	0	11,848	29.00		
30.00	Administrative Costs	257,583	755,864	1,013,447	0	1,013,447	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	257,583	767,712	1,025,295	0	1,025,295	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,092,905	834,993	2,927,898	0	2,927,898	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8607

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		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	477,985	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	883,924	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	229,968	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	243,171	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,835,048	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	46,693	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	20,588	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	67,281	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,902,329	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	274	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	274	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	11,848	29.00
30.00	Administrative Costs	490	1,013,937	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	490	1,025,785	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	490	2,928,388	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8606

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

						RHC V		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	11,308	0	11,308	0	11,308	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	244,927	0	244,927	0	244,927	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	16,519	0	16,519	0	16,519	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	45,127	0	45,127	0	45,127	9.00		
10.00	Subtotal (sum of lines 1 through 9)	317,881	0	317,881	0	317,881	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	3,252	3,252	0	3,252	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	3,252	3,252	0	3,252	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	317,881	3,252	321,133	0	321,133	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs	0	0	0	0	0	27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	16,533	16,533	0	16,533	29.00		
30.00	Administrative Costs	53,948	95,052	149,000	0	149,000	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	53,948	111,585	165,533	0	165,533	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	371,829	114,837	486,666	0	486,666	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320

Period:

Worksheet M-1

Component CCN: 14-8606

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

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	11,308	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	244,927	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	16,519	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	45,127	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	317,881	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	3,252	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	3,252	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	321,133	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	16,533	29.00
30.00	Administrative Costs	-9,695	139,305	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-9,695	155,838	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-9,695	476,971	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-3987

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	6.48	27,033	1	6		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	7.84	14,242	1	8		3.00
4.00	Subtotal (sum of lines 1 through 3)	14.32	41,275		14	41,275	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)	14.32	41,275			41,275	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)					6,553,484	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					85,561	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					6,639,045	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.987112	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					3,823,396	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,414,029	15.00
16.00	Total overhead (sum of lines 14 and 15)					6,237,425	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					6,237,425	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					6,157,037	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					12,710,521	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-3989

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		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	1	0
2.00	Physician Assistant	0.00	0	1	0
3.00	Nurse Practitioner	1.69	2,963	1	2
4.00	Subtotal (sum of lines 1 through 3)	1.69	2,963	2	2,963
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)	1.69	2,963		2,963
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)				337,559
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				5,063
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				342,622
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.985223
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				192,012
15.00	Parent provider overhead allocated to facility (see instructions)				176,462
16.00	Total overhead (sum of lines 14 and 15)				368,474
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				368,474
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				363,029
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				700,588

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8596

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		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	0.54	1,039	1	1
2.00	Physician Assistant	0.00	0	1	0
3.00	Nurse Practitioner	0.83	1,261	1	1
4.00	Subtotal (sum of lines 1 through 3)	1.37	2,300	2	2,300
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)	1.37	2,300		2,300
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)				495,568
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				776
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				496,344
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.998437
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				172,246
15.00	Parent provider overhead allocated to facility (see instructions)				154,265
16.00	Total overhead (sum of lines 14 and 15)				326,511
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				326,511
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				326,001
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				821,569

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8607

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

		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	0.69	1,163	1	1
2.00	Physician Assistant	0.63	1,617	1	1
3.00	Nurse Practitioner	2.58	9,682	1	3
4.00	Subtotal (sum of lines 1 through 3)	3.90	12,462	5	12,462
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)	3.90	12,462		12,462
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)				1,902,329
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				274
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,902,603
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.999856
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				1,025,785
15.00	Parent provider overhead allocated to facility (see instructions)				1,061,675
16.00	Total overhead (sum of lines 14 and 15)				2,087,460
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				2,087,460
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,087,159
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,989,488

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320

Period:

Worksheet M-2

Component CCN: 14-8606

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/6/2021 2:05 pm

				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	0.10	261	1	0		1.00
2.00	Physician Assistant	0.16	454	1	0		2.00
3.00	Nurse Practitioner	1.44	4,487	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.70	5,202		1	5,202	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)	1.70	5,202			5,202	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)					321,133	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)					321,133	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)					155,838	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					166,379	15.00
16.00	Total overhead (sum of lines 14 and 15)					322,217	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					322,217	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					322,217	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					643,350	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 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-3987		Date/Time Prepared: 7/6/2021 2:05 pm	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			12,710,521	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			366,090	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			12,344,431	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			41,275	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)			41,275	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			299.08	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		299.08	299.08	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	12,015	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	3,593,446	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	3,593,446	16.00
16.01	Total program charges (see instructions)(from contractor's records)			2,163,428	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			62,588	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			103,958	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.)			2,614,792	16.04
16.05	Total program cost (see instructions)		0	2,718,750	16.05
17.00	Primary payer amounts			313	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			220,998	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			370,514	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			2,718,437	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			119,959	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			2,838,396	22.00
23.00	Allowable bad debts (see instructions)			164,902	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			107,186	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			142,534	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)			2,945,582	26.00
26.01	Sequestration adjustment (see instructions)			19,441	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			2,555,406	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)			370,735	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			164,902	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 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-3989		Date/Time Prepared: 7/6/2021 2:05 pm	
		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)			700,588	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			48,086	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			652,502	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,963	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)			2,963	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			220.22	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		220.22	220.22	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	457	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	100,641	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	100,641	16.00
16.01	Total program charges (see instructions)(from contractor's records)			85,425	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			6,771	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			7,977	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.)			65,928	16.04
16.05	Total program cost (see instructions)		0	73,905	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			10,254	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			13,527	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			73,905	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			17,972	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			91,877	22.00
23.00	Allowable bad debts (see instructions)			4,444	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			2,889	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,383	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)			94,766	26.00
26.01	Sequestration adjustment (see instructions)			625	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			63,868	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)			30,273	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			4,444	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 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-8596		Date/Time Prepared: 7/6/2021 2:05 pm	
		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)			821,569	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			26,113	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			795,456	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,300	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)			2,300	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			345.85	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		345.85	345.85	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	683	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	236,216	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	236,216	16.00
16.01	Total program charges (see instructions)(from contractor's records)			118,159	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			3,285	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			6,567	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.)			170,838	16.04
16.05	Total program cost (see instructions)		0	177,405	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			16,102	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			19,482	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			177,405	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,315	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			187,720	22.00
23.00	Allowable bad debts (see instructions)			709	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			461	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			24	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)			188,181	26.00
26.01	Sequestration adjustment (see instructions)			1,242	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			100,045	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)			86,894	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			248	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 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-8607		Date/Time Prepared: 7/6/2021 2:05 pm	
		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)			3,989,488	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			6,775	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,982,713	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,462	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			12,462	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			319.59	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		319.59	319.59	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,149	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	367,209	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	367,209	16.00
16.01	Total program charges (see instructions)(from contractor's records)			240,433	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			1,282	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			1,958	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.)			277,538	16.04
16.05	Total program cost (see instructions)		0	279,496	16.05
17.00	Primary payer amounts			31	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			18,329	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			37,872	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			279,465	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			3,093	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			282,558	22.00
23.00	Allowable bad debts (see instructions)			4,367	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			2,839	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,187	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)			285,397	26.00
26.01	Sequestration adjustment (see instructions)			1,884	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			223,569	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)			59,944	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			1,528	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1320 Component CCN: 14-8606	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/6/2021 2:05 pm		
			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)			643,350	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			2,763	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			640,587	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,202	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)			5,202	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			123.14	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			123.14	123.14	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	510	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	62,801	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	62,801	16.00
16.01	Total program charges (see instructions)(from contractor's records)				86,836	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.)				41,603	16.04
16.05	Total program cost (see instructions)			0	41,603	16.05
17.00	Primary payer amounts				3	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				10,797	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				12,347	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				41,600	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				953	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				42,553	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)				42,553	26.00
26.01	Sequestration adjustment (see instructions)				281	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				42,214	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)				58	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 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/6/2021 2:05 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		6,332,077	6,332,077	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003257	0.007000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		20,624	44,325	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		83,098	40,708	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		103,722	85,033	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		6,553,484	6,553,484	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		6,157,037	6,157,037	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.015827	0.012975	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		97,447	79,888	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		201,169	164,921	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		582	1,251	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		345.65	131.83	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		180	438	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		62,217	57,742	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)			366,090	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)			119,959	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/6/2021 2:05 pm	
		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)		304,202	304,202	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003319	0.012281	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,010	3,736	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		9,995	8,428	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		11,005	12,164	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		337,559	337,559	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		363,029	363,029	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.032602	0.036035	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		11,835	13,082	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		22,840	25,246	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		70	259	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		326.29	97.47	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		27	94	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		8,810	9,162	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)			48,086	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)			17,972	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1320 Component CCN: 14-8596	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/6/2021 2:05 pm	
		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)		486,303	486,303	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000819	0.012807	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		398	6,228	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,999	7,126	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		2,397	13,354	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		495,568	495,568	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		326,001	326,001	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.004837	0.026947	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,577	8,785	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		3,974	22,139	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		14	219	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		283.86	101.09	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		5	88	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,419	8,896	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)			26,113	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)			10,315	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1320 Component CCN: 14-8607	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/6/2021 2:05 pm	
		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)		1,835,048	1,835,048	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000945	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	1,734	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	1,497	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	3,231	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,902,329	1,902,329	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,087,159	2,087,159	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.001698	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	3,544	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	6,775	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	46	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	147.28	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	21	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	3,093	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)			6,775	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)			3,093	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1320 Component CCN: 14-8606	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/6/2021 2:05 pm	
		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)		317,881	317,881	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.001367	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	435	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	944	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	1,379	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		321,133	321,133	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		322,217	322,217	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.004294	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	1,384	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	2,763	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	29	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	95.28	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	10	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	953	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)			2,763	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)			953	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 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/6/2021 2:05 pm	
			RHC I	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,396,758	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		05/13/2020	158,648		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)		158,648		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,555,406		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		370,735		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		2,926,141		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 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/6/2021 2:05 pm	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			61,983	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			05/13/2020	1,885	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)			1,885	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			63,868	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			30,273	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			94,141	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 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/6/2021 2:05 pm	
		RHC III	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		75,317	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		05/13/2020	24,728	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)		24,728	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		100,045	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		86,894	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		186,939	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 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/6/2021 2:05 pm	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			177,968	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			05/13/2020	45,601	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)			45,601	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			223,569	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			59,944	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			283,513	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 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/6/2021 2:05 pm	
			RHC V	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			33,393	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	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			05/13/2020	8,821	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)			8,821	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			42,214	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			58	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			42,272	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00