

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

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

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

Provider CCN: 14-1327

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/24/2021 3:02 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/24/2021	Time: 3:02 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH GENERAL HOSPITAL (14-1327) 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) KARISSA TURNER

Officer or Administrator of Provider(s)

PRESIDENT & 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	684,109	520,957	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	81,527	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		11,933		0	10.00
10.01	RURAL HEALTH CLINIC II	0		248,513		0	10.01
10.02	RURAL HEALTH CLINIC III	0		157,290		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		127,171		0	10.03
10.04	RURAL HEALTH CLINIC V	0		30,200		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		188,212		0	10.05
200.00	Total	0	765,636	1,284,276	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: 14-1327		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/24/2021 3:02 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1418 COLLEGE DRIVE			PO Box:				1.00		
2.00	City: MT. CARMEL			State: IL		Zip Code: 62863		County: WABASH		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		WABASH GENERAL HOSPITAL	141327	99914	1	06/01/2003	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		WABASH GENERAL HOSPITAL SWING BEDS	142327	14999		06/01/2003	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N
15.01	Hospital-Based Health Clinic - RHC		WABASH PRIMARY CARE	148568	14999		08/09/2016	N	O	N
15.02	Hospital-Based Health Clinic - RHC		WABASH PRIMARY CARE - COLLEGE DR	148579	14999		10/01/2017	N	O	N
15.03	Hospital-Based Health Clinic - RHC		WABASH PRIMARY CARE - OAK STREET	148599	14999		07/01/2019	N	O	N
15.04	Hospital-Based Health Clinic - RHC		WABASH PRIMARY CARE - ALBION	148601	14999		08/09/2019	N	O	N
15.05	Hospital-Based Health Clinic - RHC		WABASH GENERAL HOSPITAL - GRAYVILLE	148613	14999		07/27/2020	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
5/24/2021 3:02 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	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/24/2021 3:02 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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/24/2021 3:02 pm	
				V	XIX		
				1.00	2.00		
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.			Y		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		110.00	
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00	
						1.00	2.00
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	
						1.00	2.00
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N		0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N		116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			N		117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			0		118.00	
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			0	0	0118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y		121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N		122.00	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/24/2021 3:02 pm	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 5/24/2021 3:02 pm
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1327		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 5/24/2021 3:02 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/05/2021	Y	01/05/2021		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
5/24/2021 3:02 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
5/24/2021 3:02 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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/24/2021 3:02 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 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	21	7,686	43,176.00	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)		21	7,686	43,176.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	1,632.00	0	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	44,808.00	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
26.05 RURAL HEALTH CLINIC VI	88.05				0	26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	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)		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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/24/2021 3:02 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)	1,174	8	1,799			1.00
2.00 HMO and other (see instructions)	83	108				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	385	0	385			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	111			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,559	8	2,295			7.00
8.00 INTENSIVE CARE UNIT	17	10	68			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)	1,576	18	2,363	0.00	316.42	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	198	0	2,345	0.00	1.53	26.00
26.01 RURAL HEALTH CLINIC II	1,531	0	6,732	0.00	18.83	26.01
26.02 RURAL HEALTH CLINIC III	3,359	0	6,861	0.00	7.74	26.02
26.03 RURAL HEALTH CLINIC IV	2,433	0	6,689	0.00	8.57	26.03
26.04 RURAL HEALTH CLINIC V	811	0	2,861	0.00	7.39	26.04
26.05 RURAL HEALTH CLINIC VI	585	0	1,385	0.00	3.59	26.05
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	364.07	27.00
28.00 Observation Bed Days		0	183			28.00
29.00 Ambulance Trips	743					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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/24/2021 3:02 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	383	3	645	1.00
2.00 HMO and other (see instructions)			29	37		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	383	3	645	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
26.05 RURAL HEALTH CLINIC VI	0.00					26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

Worksheet S-8

Component CCN: 14-8501

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

		RHC I		Cost		
		1.00				
Clinic Address and Identification						
1.00	Street		1418 COLLEGE DRIVE			1.00
	City		State	ZIP Code		
	1.00		2.00	3.00		
2.00	City, State, ZIP Code, County		MT.CARMEIL IL 62863			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	from
		1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)						
11.00	CLINIC	10:00	22:00	15:00	21:00	15:00
				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	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00

MCRIF32 - 16.9.172.7

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

Worksheet S-8

Component CCN: 14-8568

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		1123 CHESTNUT STREET		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		MOUNT CARMEL IL 62863-1212		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	
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
		County		4.00	
2.00	City, State, ZIP Code, County		WABASH		2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		18:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

From 01/01/2020

To 12/31/2020

Worksheet S-8

Component CCN: 14-8568

Date/Time Prepared:
5/24/2021 3:02 pm

RHC II

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	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8579		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 5/24/2021 3:02 pm	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1418 COLLEGE DR			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			MOUNT CARMEL		IL 62863		2.00	
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		17:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			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	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			WABASH				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00		08:00		17:00	
				08:00		17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1327	Period: From 01/01/2020	Worksheet S-8	
			Component CCN: 14-8579	To 12/31/2020	Date/Time Prepared: 5/24/2021 3:02 pm	
			RHC III			Cost
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8599		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 5/24/2021 3:02 pm	
				RHC IV		Cost			
				1.00					
1.00	Clinic Address and Identification			1106 OAK STREET				1.00	
	Street			City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			MOUNT CARMEL		IL 62863		2.00	
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
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							14.00	
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County		4.00			
2.00	City, State, ZIP Code, County			WABASH				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)			CLINIC		17:00 08:00		17:00 08:00	
						17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1327 Component CCN: 14-8599	Period: From 01/01/2020 To 12/31/2020	Worksheet S-8 Date/Time Prepared: 5/24/2021 3:02 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	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8601		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 5/24/2021 3:02 pm		
				RHC V		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				26 EAST ELM STREET			1.00		
				City		State		ZIP Code		
				1.00		2.00		3.00		
2.00	City, State, ZIP Code, County				ALBION IL 62806			2.00		
								1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00	
				Grant Award		Date				
				1.00		2.00				
Source of Federal Funds										
4.00	Community Health Center (Section 330(d), PHS Act)							4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00		
7.00	Appalachian Regional Commission							7.00		
8.00	Look-Alikes							8.00		
9.00	OTHER (SPECIFY)							9.00		
				1.00		2.00				
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00	
				Sunday		Monday		Tuesday		
				from to		from to		from		
				1.00 2.00		3.00 4.00		5.00		
Facility hours of operations (1)										
11.00	CLINIC				08:00		17:00		08:00	
				1.00		2.00				
12.00	Have you received an approval for an exception to the productivity standard?				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		Total Visits		
				1.00		2.00		3.00 4.00 5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00	
				County						
				4.00						
2.00	City, State, ZIP Code, County				EDWARDS				2.00	
				Tuesday		Wednesday		Thursday		
				to		from to		from to		
				6.00		7.00 8.00		9.00 10.00		
Facility hours of operations (1)										
11.00	CLINIC				17:00		08:00		17:00	
				09:00		18:00		11.00		

Health Financial Systems		WABASH GENERAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1327	Period: From 01/01/2020	Worksheet S-8
			Component CCN: 14-8601	To 12/31/2020	Date/Time Prepared: 5/24/2021 3:02 pm
			RHC V		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	07:00	16:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8613		Period: From 01/01/2020 To 12/31/2020		Worksheet S-8 Date/Time Prepared: 5/24/2021 3:02 pm	
				RHC VI		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1418 COLLEGE DRIVE			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			MOUNT CARMEL		IL 62863		2.00	
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			10:00	22:00	15:00	21:00	15:00	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							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			WABASH				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			21:00	18:00	21:00	18:00	21:00	11.00

Health Financial Systems		WABASH GENERAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1327	Period: From 01/01/2020	Worksheet S-8
			Component CCN: 14-8613	To 12/31/2020	Date/Time Prepared: 5/24/2021 3:02 pm
			RHC VI		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	15:00	21:00	10:00	22:00
					11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 5/24/2021 3:02 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)			0.397533 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,870,807		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	13,797,688		6.00
7.00	Medicaid cost (line 1 times line 6)	5,485,036		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)	2,614,229		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)	2,614,229		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	160,229	0	160,229 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	63,696	0	63,696 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	63,696	0	63,696 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,690,531		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	292,973		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	450,727		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,239,804		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,445,683		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,509,379		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,123,608		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1327

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

Worksheet A

Date/Time Prepared:
5/24/2021 3:02 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,329,260	1,329,260	0	1,329,260	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		854,706	854,706	715,162	1,569,868	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	252,557	5,447,173	5,699,730	0	5,699,730	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,304,152	4,822,796	7,126,948	-128,396	6,998,552	5.00
7.00	00700	OPERATION OF PLANT	281,813	1,235,198	1,517,011	-45,489	1,471,522	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	127,696	127,696	8.00
9.00	00900	HOUSEKEEPING	301,770	59,820	361,590	0	361,590	9.00
10.00	01000	DIETARY	377,249	261,314	638,563	-515,581	122,982	10.00
11.00	01100	CAFETERIA	0	0	0	512,912	512,912	11.00
13.00	01300	NURSING ADMINISTRATION	116,059	119	116,178	0	116,178	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	560,293	86,698	646,991	-2,717	644,274	16.00
17.00	01700	SOCIAL SERVICE	135,756	12,004	147,760	0	147,760	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	904,085	106,583	1,010,668	-10,445	1,000,223	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,408,625	1,062,374	2,470,999	-36,245	2,434,754	30.00
31.00	03100	INTENSIVE CARE UNIT	311,297	3,597	314,894	0	314,894	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	960,120	3,421,380	4,381,500	-2,927,967	1,453,533	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	889,129	924,600	1,813,729	-135,058	1,678,671	54.00
60.00	06000	LABORATORY	900,013	1,432,000	2,332,013	-29,121	2,302,892	60.00
65.00	06500	RESPIRATORY THERAPY	739,236	130,055	869,291	-18,603	850,688	65.00
66.00	06600	PHYSICAL THERAPY	1,022,946	184,510	1,207,456	-11,708	1,195,748	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	238,755	117,715	356,470	683,577	1,040,047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,344,132	2,344,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	443,866	2,370,824	2,814,690	-524	2,814,166	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	74,396	181,430	255,826	1,747	257,573	88.00
88.01	08802	RURAL HEALTH CLINIC II	1,529,515	154,730	1,684,245	0	1,684,245	88.01
88.02	08801	RURAL HEALTH CLINIC III	801,638	38,702	840,340	0	840,340	88.02
88.03	08803	RURAL HEALTH CLINIC IV	742,964	54,477	797,441	0	797,441	88.03
88.04	08804	RURAL HEALTH CLINIC V	482,178	45,395	527,573	-1,747	525,826	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	227,725	227,725	88.05
90.00	09000	CLINIC	316,195	326,863	643,058	-3,413	639,645	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,523,324	440,676	3,964,000	-186,816	3,777,184	90.01
90.02	09002	SURGICAL CLINIC	492,369	198,843	691,212	-5,536	685,676	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	64,004	42,568	106,572	0	106,572	90.04
90.05	09005	ENT CLINIC	4,086	101,504	105,590	-1,640	103,950	90.05
91.00	09100	EMERGENCY	1,009,707	1,241,683	2,251,390	-7,372	2,244,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	937,308	121,006	1,058,314	-15,289	1,043,025	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		301,559	301,559	-301,559	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,125,405	27,112,162	49,237,567	227,725	49,465,292	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	557,814	136,052	693,866	-227,725	466,141	192.00
192.01	19201	OUTREACH	218,358	6,065	224,423	0	224,423	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	22,901,577	27,254,279	50,155,856	0	50,155,856	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1327

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

Worksheet A

Date/Time Prepared:
5/24/2021 3:02 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	0	1,329,260	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-267,109	1,302,759	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-191,287	5,508,443	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-503,164	6,495,388	5.00
7.00	00700	OPERATION OF PLANT	0	1,471,522	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,696	8.00
9.00	00900	HOUSEKEEPING	0	361,590	9.00
10.00	01000	DIETARY	0	122,982	10.00
11.00	01100	CAFETERIA	-126,290	386,622	11.00
13.00	01300	NURSING ADMINISTRATION	0	116,178	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,870	639,404	16.00
17.00	01700	SOCIAL SERVICE	0	147,760	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-904,085	96,138	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-943,246	1,491,508	30.00
31.00	03100	INTENSIVE CARE UNIT	0	314,894	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,453,533	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,504	1,677,167	54.00
60.00	06000	LABORATORY	-63,798	2,239,094	60.00
65.00	06500	RESPIRATORY THERAPY	-108,625	742,063	65.00
66.00	06600	PHYSICAL THERAPY	0	1,195,748	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,349	1,038,698	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,344,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,024	2,813,142	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	257,573	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	1,684,245	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	840,340	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	797,441	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	525,826	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	227,725	88.05
90.00	09000	CLINIC	-266,100	373,545	90.00
90.01	09001	ORTHOPAEDIC CLINIC	-2,504,892	1,272,292	90.01
90.02	09002	SURGICAL CLINIC	-382,850	302,826	90.02
90.03	09003	OP CLINIC	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	-27,280	79,292	90.04
90.05	09005	ENT CLINIC	0	103,950	90.05
91.00	09100	EMERGENCY	0	2,244,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	1,043,025	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,297,473	43,167,819	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	466,141	192.00
192.01	19201	OUTREACH	0	224,423	192.01
192.02	19202	CLINIC	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,297,473	43,858,383	200.00

RECLASSIFICATIONS

Provider CCN: 14-1327

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

Worksheet A-6

Date/Time Prepared:
5/24/2021 3:02 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENT RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	301,081		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
	TOTALS		0	301,081		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	304,289	208,623		1.00
	0		304,289	208,623		
	C - INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	301,559		1.00
	0		0	301,559		
	D - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,470		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	12,470		
	E - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	798,803		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	0		0	798,803		
	F - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	4,423		1.00
	TOTALS		0	4,423		
	G - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,344,132		1.00
	0		0	2,344,132		
	H - LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	127,696		1.00
	0		0	127,696		
	I - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	112,522		1.00
	0		0	112,522		
	J - RHC RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	1,747	0		1.00
	0		1,747	0		
	K - GRAYVILLE RHC					
1.00	RURAL HEALTH CLINIC VI	88.05	209,194	18,531		1.00
	TOTALS		209,194	18,531		
500.00	Grand Total: Increases		515,230	4,229,840		500.00

RECLASSIFICATIONS

Provider CCN: 14-1327

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

Worksheet A-6

Date/Time Prepared:
5/24/2021 3:02 pm

	Decreases						5/24/2021 3:02 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,874	10		1.00
2.00	OPERATION OF PLANT	7.00	0	49,912	0		2.00
3.00	DIETARY	10.00	0	2,669	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,717	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,680	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	134,494	0		6.00
7.00	LABORATORY	60.00	0	28,927	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	1,957	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	11,708	0		9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	0	524	0		10.00
11.00	CLINIC	90.00	0	376	0		11.00
12.00	ORTHOPAEDIC CLINIC	90.01	0	32,510	0		12.00
13.00	EMERGENCY	91.00	0	2,820	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	13,913	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES				0		15.00
	TOTALS		0	301,081			
	B - CAFETERIA						
1.00	DIETARY	10.00	304,289	208,623	0		1.00
	0		304,289	208,623			
	C - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	301,559	9		1.00
	0		0	301,559			
	D - OXYGEN						
1.00	OPERATING ROOM	50.00	0	352	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	11,189	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	929	0		3.00
	0		0	12,470			
	E - MED SUPPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	10,445	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	33,565	0		2.00
3.00	OPERATING ROOM	50.00	0	583,483	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	564	0		4.00
5.00	LABORATORY	60.00	0	194	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	5,457	0		6.00
7.00	CLINIC	90.00	0	3,037	0		7.00
8.00	ORTHOPAEDIC CLINIC	90.01	0	154,306	0		8.00
9.00	SURGICAL CLINIC	90.02	0	1,113	0		9.00
10.00	ENT CLINIC	90.05	0	1,640	0		10.00
11.00	EMERGENCY	91.00	0	4,552	0		11.00
12.00	AMBULANCE SERVICES	95.00	0	447	0		12.00
	0		0	798,803			
	F - UTILITIES RECLASS						
1.00	SURGICAL CLINIC	90.02	0	4,423	0		1.00
	TOTALS		0	4,423			
	G - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	2,344,132	0		1.00
	0		0	2,344,132			
	H - LINEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	127,696	0		1.00
	0		0	127,696			
	I - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	112,522	9		1.00
	0		0	112,522			
	J - RHC RECLASS						
1.00	RURAL HEALTH CLINIC V	88.04	1,747	0	0		1.00
	0		1,747	0			
	K - GRAYVILLE RHC						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	209,194	18,531	0		1.00
	TOTALS		209,194	18,531			
500.00	Grand Total: Decreases		515,230	4,229,840			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
5/24/2021 3:02 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	546,914	15,523	0	15,523	0	1.00	
2.00	Land Improvements	2,101,828	180,171	0	180,171	0	2.00	
3.00	Buildings and Fixtures	27,542,055	1,416,290	0	1,416,290	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	4,919,416	362,377	0	362,377	0	5.00	
6.00	Movable Equipment	16,019,906	1,761,502	0	1,761,502	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	51,130,119	3,735,863	0	3,735,863	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	51,130,119	3,735,863	0	3,735,863	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	562,437	0				1.00	
2.00	Land Improvements	2,281,999	0				2.00	
3.00	Buildings and Fixtures	28,958,345	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	5,281,793	0				5.00	
6.00	Movable Equipment	17,781,408	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	54,865,982	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	54,865,982	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
5/24/2021 3:02 pm

07/27/2021 0:02 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	1,329,260	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	854,706	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,183,966	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,329,260				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	854,706				2.00
3.00	Total (sum of lines 1-2)	0	2,183,966				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
5/24/2021 3:02 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	37,084,574	0	37,084,574	0.675912	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	17,781,408	0	17,781,408	0.324088	0	2.00
3.00	Total (sum of lines 1-2)	54,865,982	0	54,865,982	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,329,260	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,001,678	301,081	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,330,938	301,081	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,329,260	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,302,759	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,632,019	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1327

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

Worksheet A-8

Date/Time Prepared:
5/24/2021 3:02 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	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-283,098	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-30,266	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-4,296,791			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,504			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-126,290	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,349	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,024	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,870	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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1327

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

Worksheet A-8

Date/Time Prepared:
5/24/2021 3:02 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	A&G OTHER REVENUE	B	-53,887	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN RECRUITMENT - ADMIN	A	-340,986	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN RECRUITMENT - PERSONNEL	A	-24,635	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	PUBLIC RELATIONS - PERSONNEL	A	-38,724	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	PUBLIC RELATIONS - MARKETING	A	-62,195	ADMINISTRATIVE & GENERAL	5.00	0	36.01
37.00	LOBBYING DUES	A	-15,830	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	CRNA SALARY	A	-904,085	NONPHYSICIAN ANESTHETISTS	19.00	0	38.00
39.00	CRNA EMP BEN	A	-127,928	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	BOND INSURANCE	A	15,989	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,297,473				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1327

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2021 3:02 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	255,908	257,412	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		0	255,908	257,412	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	A	DSS MRI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1327

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2021 3:02 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-1,504	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,504			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1327

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2021 3:02 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	943,246	943,246	0	0	0	1.00
2.00	60.00	LABORATORY	63,798	63,798	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	108,625	108,625	0	0	0	3.00
4.00	90.00	CLINIC	266,100	266,100	0	0	0	4.00
5.00	90.01	ORTHOPAEDIC CLINIC	2,560,246	2,504,892	55,354	0	0	5.00
6.00	90.02	SURGICAL CLINIC	399,682	382,850	16,832	0	0	6.00
7.00	90.04	MENTAL HEALTH CLINIC	27,280	27,280	0	0	0	7.00
8.00	91.00	EMERGENCY	1,099,800	0	1,099,800	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,468,777	4,296,791	1,171,986		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	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	5.00
6.00	90.02	SURGICAL CLINIC	0	0	0	0	0	6.00
7.00	90.04	MENTAL HEALTH CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	943,246		1.00
2.00	60.00	LABORATORY	0	0	0	63,798		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	108,625		3.00
4.00	90.00	CLINIC	0	0	0	266,100		4.00
5.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	2,504,892		5.00
6.00	90.02	SURGICAL CLINIC	0	0	0	382,850		6.00
7.00	90.04	MENTAL HEALTH CLINIC	0	0	0	27,280		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,296,791		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/24/2021 3:02 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,329,260	1,329,260			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,302,759	1,302,759			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,508,443	6,511	6,381	5,521,335	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,495,388	88,908	87,135	561,702	5.00
7.00	00700	OPERATION OF PLANT	1,471,522	52,775	51,723	68,700	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	127,696	0	0	0	8.00
9.00	00900	HOUSEKEEPING	361,590	5,171	5,068	73,565	9.00
10.00	01000	DIETARY	122,982	40,382	39,577	17,786	10.00
11.00	01100	CAFETERIA	386,622	16,245	15,921	74,179	11.00
13.00	01300	NURSING ADMINISTRATION	116,178	3,056	2,995	28,293	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	639,404	17,857	17,501	136,587	16.00
17.00	01700	SOCIAL SERVICE	147,760	3,726	3,652	33,094	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	96,138	0	0	220,396	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,491,508	165,213	161,919	343,392	30.00
31.00	03100	INTENSIVE CARE UNIT	314,894	16,685	16,352	75,887	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,453,533	258,747	253,588	234,056	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,677,167	55,224	54,123	216,750	54.00
60.00	06000	LABORATORY	2,239,094	39,377	38,592	219,403	60.00
65.00	06500	RESPIRATORY THERAPY	742,063	17,292	16,947	180,209	65.00
66.00	06600	PHYSICAL THERAPY	1,195,748	85,412	83,709	249,372	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,038,698	49,216	48,235	58,203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,344,132	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,813,142	11,618	11,387	108,205	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	257,573	19,553	19,163	18,562	88.00
88.01	08802	RURAL HEALTH CLINIC II	1,684,245	0	0	372,862	88.01
88.02	08801	RURAL HEALTH CLINIC III	840,340	83,737	82,067	195,422	88.02
88.03	08803	RURAL HEALTH CLINIC IV	797,441	0	0	181,118	88.03
88.04	08804	RURAL HEALTH CLINIC V	525,826	0	0	117,119	88.04
88.05	08805	RURAL HEALTH CLINIC VI	227,725	100,484	98,481	50,997	88.05
90.00	09000	CLINIC	373,545	42,517	41,670	77,081	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,272,292	0	0	858,911	90.01
90.02	09002	SURGICAL CLINIC	302,826	0	0	120,029	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	79,292	17,124	16,783	15,603	90.04
90.05	09005	ENT CLINIC	103,950	0	0	996	90.05
91.00	09100	EMERGENCY	2,244,018	46,809	45,876	246,144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,043,025	74,693	73,204	228,495	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,167,819	1,318,332	1,292,049	5,383,118	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,606	4,514	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	466,141	6,322	6,196	84,986	192.00
192.01	19201	OUTREACH	224,423	0	0	53,231	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
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)	43,858,383	1,329,260	1,302,759	5,521,335	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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
5.00	00500	ADMINISTRATIVE & GENERAL	7,233,133					5.00
7.00	00700	OPERATION OF PLANT	324,816	1,969,536				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,219	0	152,915			8.00
9.00	00900	HOUSEKEEPING	87,961	8,937	0	542,292		9.00
10.00	01000	DIETARY	43,591	69,794	1,678	19,305	355,095	10.00
11.00	01100	CAFETERIA	97,356	28,077	0	7,766	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,727	5,282	0	1,461	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,233	30,863	0	8,536	0	16.00
17.00	01700	SOCIAL SERVICE	37,174	6,440	0	1,781	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	62,512	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	426,980	285,544	62,185	78,980	342,137	30.00
31.00	03100	INTENSIVE CARE UNIT	83,700	28,837	0	7,976	12,958	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	434,463	447,202	34,964	123,696	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	395,625	95,447	14,958	26,400	0	54.00
60.00	06000	LABORATORY	500,927	68,057	520	18,824	0	60.00
65.00	06500	RESPIRATORY THERAPY	188,901	29,886	2,955	8,266	0	65.00
66.00	06600	PHYSICAL THERAPY	318,796	147,620	11,551	40,831	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	235,873	85,063	0	23,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	462,943	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	581,492	20,081	0	5,554	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	62,180	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	406,258	0	193	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	237,297	0	520	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	193,256	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	126,975	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	94,338	0	0	0	0	88.05
90.00	09000	CLINIC	105,620	73,484	1,002	20,325	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	420,891	280,442	0	77,569	0	90.01
90.02	09002	SURGICAL CLINIC	83,510	0	30	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	25,437	29,596	0	8,186	0	90.04
90.05	09005	ENT CLINIC	20,726	0	0	0	0	90.05
91.00	09100	EMERGENCY	510,086	80,902	20,674	22,377	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	280,321	129,095	1,685	35,707	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,065,184	1,950,649	152,915	537,068	355,095	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,801	7,960	0	2,202	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	111,314	10,927	0	3,022	0	192.00
192.01	19201	OUTREACH	54,834	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,233,133	1,969,536	152,915	542,292	355,095	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	626,166					11.00
13.00	01300	NURSING ADMINISTRATION	3,177	190,169				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,958	0	1,052,939			16.00
17.00	01700	SOCIAL SERVICE	6,711	0	0	240,338		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	379,046	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	85,134	72,860	156,231	231,584	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,273	13,927	0	8,754	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	71,356	61,069	139,134	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	379,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,943	0	43,037	0	0	54.00
60.00	06000	LABORATORY	46,442	0	24,172	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	31,981	0	29,478	0	0	65.00
66.00	06600	PHYSICAL THERAPY	50,926	0	27,709	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,431	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	14,728	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	53,649	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	67,209	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	90,791	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	89,022	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	35,373	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	16,035	0	85,485	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	99,358	0	151,515	0	0	90.01
90.02	09002	SURGICAL CLINIC	12,590	0	17,097	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	3,415	0	0	0	0	90.04
90.05	09005	ENT CLINIC	267	0	0	0	0	90.05
91.00	09100	EMERGENCY	49,441	42,313	43,037	0	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)	626,166	190,169	1,052,939	240,338	379,046	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	0	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
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)	626,166	190,169	1,052,939	240,338	379,046	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,903,667	0	3,903,667	30.00
31.00	03100	INTENSIVE CARE UNIT	596,243	0	596,243	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,511,808	0	3,511,808	50.00
53.00	05300	ANESTHESIOLOGY	379,046	0	379,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,640,674	0	2,640,674	54.00
60.00	06000	LABORATORY	3,195,408	0	3,195,408	60.00
65.00	06500	RESPIRATORY THERAPY	1,247,978	0	1,247,978	65.00
66.00	06600	PHYSICAL THERAPY	2,211,674	0	2,211,674	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,553,247	0	1,553,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,807,075	0	2,807,075	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,566,207	0	3,566,207	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	430,680	0	430,680	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,530,767	0	2,530,767	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,530,174	0	1,530,174	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,260,837	0	1,260,837	88.03
88.04	08804	RURAL HEALTH CLINIC V	805,293	0	805,293	88.04
88.05	08805	RURAL HEALTH CLINIC VI	572,025	0	572,025	88.05
90.00	09000	CLINIC	836,764	0	836,764	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,160,978	0	3,160,978	90.01
90.02	09002	SURGICAL CLINIC	536,082	0	536,082	90.02
90.03	09003	OP CLINIC	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	195,436	0	195,436	90.04
90.05	09005	ENT CLINIC	125,939	0	125,939	90.05
91.00	09100	EMERGENCY	3,351,677	0	3,351,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,866,225	0	1,866,225	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,815,904	0	42,815,904	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,083	0	21,083	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	688,908	0	688,908	192.00
192.01	19201	OUTREACH	332,488	0	332,488	192.01
192.02	19202	CLINIC	0	0	0	192.02
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)	43,858,383	0	43,858,383	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
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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	6,511	6,381	12,892	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	88,908	87,135	176,043	5.00
7.00	00700	OPERATION OF PLANT	0	52,775	51,723	104,498	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,171	5,068	10,239	9.00
10.00	01000	DIETARY	0	40,382	39,577	79,959	10.00
11.00	01100	CAFETERIA	0	16,245	15,921	32,166	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,056	2,995	6,051	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,857	17,501	35,358	16.00
17.00	01700	SOCIAL SERVICE	0	3,726	3,652	7,378	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	165,213	161,919	327,132	30.00
31.00	03100	INTENSIVE CARE UNIT	0	16,685	16,352	33,037	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	258,747	253,588	512,335	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,224	54,123	109,347	54.00
60.00	06000	LABORATORY	0	39,377	38,592	77,969	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,292	16,947	34,239	65.00
66.00	06600	PHYSICAL THERAPY	0	85,412	83,709	169,121	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49,216	48,235	97,451	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,618	11,387	23,005	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	19,553	19,163	38,716	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	83,737	82,067	165,804	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
88.05	08805	RURAL HEALTH CLINIC VI	0	100,484	98,481	198,965	88.05
90.00	09000	CLINIC	0	42,517	41,670	84,187	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0	17,124	16,783	33,907	90.04
90.05	09005	ENT CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	46,809	45,876	92,685	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	74,693	73,204	147,897	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,318,332	1,292,049	2,610,381	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,606	4,514	9,120	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,322	6,196	12,518	192.00
192.01	19201	OUTREACH	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
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)	0	1,329,260	1,302,759	2,632,019	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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
5.00	00500	ADMINISTRATIVE & GENERAL	177,354					5.00
7.00	00700	OPERATION OF PLANT	7,964	112,622				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	618	0	618			8.00
9.00	00900	HOUSEKEEPING	2,157	511	0	13,079		9.00
10.00	01000	DIETARY	1,069	3,991	7	466	85,534	10.00
11.00	01100	CAFETERIA	2,387	1,605	0	187	0	11.00
13.00	01300	NURSING ADMINISTRATION	729	302	0	35	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,929	1,765	0	206	0	16.00
17.00	01700	SOCIAL SERVICE	911	368	0	43	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,533	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,469	16,328	251	1,905	82,413	30.00
31.00	03100	INTENSIVE CARE UNIT	2,052	1,649	0	192	3,121	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,652	25,573	141	2,984	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,700	5,458	60	637	0	54.00
60.00	06000	LABORATORY	12,282	3,892	2	454	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,631	1,709	12	199	0	65.00
66.00	06600	PHYSICAL THERAPY	7,816	8,441	47	985	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,783	4,864	0	567	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,350	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,270	1,148	0	134	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,525	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	9,961	0	1	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	5,818	0	2	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,738	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	3,113	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	2,313	0	0	0	0	88.05
90.00	09000	CLINIC	2,590	4,202	4	490	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	10,319	16,036	0	1,871	0	90.01
90.02	09002	SURGICAL CLINIC	2,047	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	624	1,692	0	197	0	90.04
90.05	09005	ENT CLINIC	508	0	0	0	0	90.05
91.00	09100	EMERGENCY	12,506	4,626	84	540	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	6,873	7,382	7	861	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	173,237	111,542	618	12,953	85,534	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	44	455	0	53	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,729	625	0	73	0	192.00
192.01	19201	OUTREACH	1,344	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
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)	177,354	112,622	618	13,079	85,534	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
From 01/01/2020
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	36,518					11.00
13.00	01300	NURSING ADMINISTRATION	185	7,368				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	44,024			16.00
17.00	01700	SOCIAL SERVICE	391	0	0	9,168		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2,047	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,965	2,823	6,533	8,834		30.00
31.00	03100	INTENSIVE CARE UNIT	949	540	0	334		31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,161	2,366	5,817	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,612	0	1,799	0		54.00
60.00	06000	LABORATORY	2,709	0	1,011	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,865	0	1,232	0		65.00
66.00	06600	PHYSICAL THERAPY	2,970	0	1,159	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	842	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	859	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	2,243	0		88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	2,810	0		88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	3,796	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	3,722	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	1,479	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0		88.05
90.00	09000	CLINIC	935	0	3,574	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	5,796	0	6,335	0		90.01
90.02	09002	SURGICAL CLINIC	734	0	715	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
90.04	09004	MENTAL HEALTH CLINIC	199	0	0	0		90.04
90.05	09005	ENT CLINIC	16	0	0	0		90.05
91.00	09100	EMERGENCY	2,883	1,639	1,799	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		95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,518	7,368	44,024	9,168	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	OUTREACH	0	0	0	0		192.01
192.02	19202	CLINIC	0	0	0	0		192.02
200.00		Cross Foot Adjustments					2,047	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,518	7,368	44,024	9,168	2,047	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	462,455	0	462,455	30.00
31.00	03100	INTENSIVE CARE UNIT	42,051	0	42,051	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	564,575	0	564,575	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	131,119	0	131,119	54.00
60.00	06000	LABORATORY	98,831	0	98,831	60.00
65.00	06500	RESPIRATORY THERAPY	44,308	0	44,308	65.00
66.00	06600	PHYSICAL THERAPY	191,121	0	191,121	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,643	0	109,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,350	0	11,350	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,669	0	39,669	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	42,527	0	42,527	88.00
88.01	08802	RURAL HEALTH CLINIC II	13,642	0	13,642	88.01
88.02	08801	RURAL HEALTH CLINIC III	175,876	0	175,876	88.02
88.03	08803	RURAL HEALTH CLINIC IV	8,883	0	8,883	88.03
88.04	08804	RURAL HEALTH CLINIC V	4,865	0	4,865	88.04
88.05	08805	RURAL HEALTH CLINIC VI	201,397	0	201,397	88.05
90.00	09000	CLINIC	96,162	0	96,162	90.00
90.01	09001	ORTHOPAEDIC CLINIC	42,368	0	42,368	90.01
90.02	09002	SURGICAL CLINIC	3,776	0	3,776	90.02
90.03	09003	OP CLINIC	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	36,655	0	36,655	90.04
90.05	09005	ENT CLINIC	526	0	526	90.05
91.00	09100	EMERGENCY	117,337	0	117,337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	163,553	0	163,553	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,602,689	0	2,602,689	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,672	0	9,672	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,143	0	16,143	192.00
192.01	19201	OUTREACH	1,468	0	1,468	192.01
192.02	19202	CLINIC	0	0	0	192.02
200.00		Cross Foot Adjustments	2,047	0	2,047	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,632,019	0	2,632,019	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1327

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	63,497				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		63,497			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	311	311	22,649,020		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,247	4,247	2,304,152	-7,233,133	5.00
7.00	00700	OPERATION OF PLANT	2,521	2,521	281,813	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	247	247	301,770	0	9.00
10.00	01000	DIETARY	1,929	1,929	72,960	0	10.00
11.00	01100	CAFETERIA	776	776	304,289	0	11.00
13.00	01300	NURSING ADMINISTRATION	146	146	116,059	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	853	560,293	0	16.00
17.00	01700	SOCIAL SERVICE	178	178	135,756	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	904,085	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,892	7,892	1,408,625	0	30.00
31.00	03100	INTENSIVE CARE UNIT	797	797	311,297	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,360	12,360	960,120	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,638	889,129	0	54.00
60.00	06000	LABORATORY	1,881	1,881	900,013	0	60.00
65.00	06500	RESPIRATORY THERAPY	826	826	739,236	0	65.00
66.00	06600	PHYSICAL THERAPY	4,080	4,080	1,022,946	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	2,351	238,755	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	555	443,866	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	934	934	76,143	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	1,529,515	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	4,000	4,000	801,638	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	742,964	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	480,431	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	4,800	4,800	209,194	0	88.05
90.00	09000	CLINIC	2,031	2,031	316,195	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	3,523,324	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	492,369	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	818	818	64,004	0	90.04
90.05	09005	ENT CLINIC	0	0	4,086	0	90.05
91.00	09100	EMERGENCY	2,236	2,236	1,009,707	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,568	3,568	937,308	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,975	62,975	22,082,042	-7,233,133	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	220	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	302	348,620	0	192.00
192.01	19201	OUTREACH	0	0	218,358	0	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,329,260	1,302,759	5,521,335	7,233,133	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.934217	20.516859	0.243778	0.197490	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,892	177,354	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000569	0.004842	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: 14-1327

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	54,435				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,599			8.00
9.00	00900	HOUSEKEEPING	247	0	54,188		9.00
10.00	01000	DIETARY	1,929	226	1,929	7,125	10.00
11.00	01100	CAFETERIA	776	0	776	0	11.00
13.00	01300	NURSING ADMINISTRATION	146	0	146	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	0	853	0	16.00
17.00	01700	SOCIAL SERVICE	178	0	178	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,892	8,377	7,892	6,865	30.00
31.00	03100	INTENSIVE CARE UNIT	797	0	797	260	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,360	4,710	12,360	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,015	2,638	0	54.00
60.00	06000	LABORATORY	1,881	70	1,881	0	60.00
65.00	06500	RESPIRATORY THERAPY	826	398	826	0	65.00
66.00	06600	PHYSICAL THERAPY	4,080	1,556	4,080	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	0	2,351	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	0	555	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	26	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	70	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
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	88.05
90.00	09000	CLINIC	2,031	135	2,031	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,751	0	7,751	0	90.01
90.02	09002	SURGICAL CLINIC	0	4	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	818	0	818	0	90.04
90.05	09005	ENT CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	2,236	2,785	2,236	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				1,665	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,568	227	3,568	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,913	20,599	53,666	7,125	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	0	220	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	0	302	0	192.00
192.01	19201	OUTREACH	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	192.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,969,536	152,915	542,292	355,095	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.181427	7.423419	10.007603	49.837895	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	112,622	618	13,079	85,534	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.068926	0.030001	0.241363	12.004772	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: 14-1327

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	16.00	17.00	19.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	7,483			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,786		16.00
17.00	01700	SOCIAL SERVICE	0	0	1,867	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,867	265	1,799	30.00
31.00	03100	INTENSIVE CARE UNIT	548	0	68	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,403	236	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73	0	54.00
60.00	06000	LABORATORY	0	41	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	50	0	65.00
66.00	06600	PHYSICAL THERAPY	0	47	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	91	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	114	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	154	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	151	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	60	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	88.05
90.00	09000	CLINIC	0	145	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	257	0	90.01
90.02	09002	SURGICAL CLINIC	0	29	0	90.02
90.03	09003	OP CLINIC	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	0	0	0	90.04
90.05	09005	ENT CLINIC	0	0	0	90.05
91.00	09100	EMERGENCY	1,665	73	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	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,483	1,786	1,867	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	OUTREACH	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	192.02
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)	190,169	1,052,939	240,338	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.413471	589.551512	128.729513	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,368	44,024	9,168	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.984632	24.649496	4.910552	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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/24/2021 3:02 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	3,903,667		3,903,667	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	596,243		596,243	0	0	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,511,808		3,511,808	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	379,046		379,046	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,640,674		2,640,674	0	0	54.00	
60.00	06000	LABORATORY	3,195,408		3,195,408	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	1,247,978	0	1,247,978	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	2,211,674	0	2,211,674	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,553,247		1,553,247	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,807,075		2,807,075	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,566,207		3,566,207	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	430,680		430,680	0	0	88.00	
88.01	08802	RURAL HEALTH CLINIC II	2,530,767		2,530,767	0	0	88.01	
88.02	08801	RURAL HEALTH CLINIC III	1,530,174		1,530,174	0	0	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	1,260,837		1,260,837	0	0	88.03	
88.04	08804	RURAL HEALTH CLINIC V	805,293		805,293	0	0	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	572,025		572,025	0	0	88.05	
90.00	09000	CLINIC	836,764		836,764	0	0	90.00	
90.01	09001	ORTHOPAEDIC CLINIC	3,160,978		3,160,978	0	0	90.01	
90.02	09002	SURGICAL CLINIC	536,082		536,082	0	0	90.02	
90.03	09003	OP CLINIC	0		0	0	0	90.03	
90.04	09004	MENTAL HEALTH CLINIC	195,436		195,436	0	0	90.04	
90.05	09005	ENT CLINIC	125,939		125,939	0	0	90.05	
91.00	09100	EMERGENCY	3,351,677		3,351,677	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	300,431		300,431	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,866,225		1,866,225	0	0	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	43,116,335	0	43,116,335	0	0	200.00	
201.00		Less Observation Beds	300,431		300,431			201.00	
202.00		Total (see instructions)	42,815,904	0	42,815,904	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
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			Title XVIII		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,982,498		2,982,498			30.00
31.00	03100	INTENSIVE CARE UNIT	82,203		82,203			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,135,610	8,558,546	18,694,156	0.187856	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,306,680	2,074,139	3,380,819	0.112117	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	713,729	16,682,127	17,395,856	0.151799	0.000000	54.00
60.00	06000	LABORATORY	1,112,054	14,253,681	15,365,735	0.207957	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	280,792	2,463,706	2,744,498	0.454720	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,261,539	5,183,211	6,444,750	0.343175	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,940,209	363,959	3,304,168	0.470087	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,494,872	210,000	12,704,872	0.220945	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,624,797	8,066,505	9,691,302	0.367980	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	295,244	295,244			88.00
88.01	08802	RURAL HEALTH CLINIC II	0	1,530,650	1,530,650			88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,051,119	1,051,119			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	885,869	885,869			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	741,065	741,065			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	223,467	223,467			88.05
90.00	09000	CLINIC	0	877,600	877,600	0.953469	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	500	1,759,152	1,759,652	1.796365	0.000000	90.01
90.02	09002	SURGICAL CLINIC	2,608	274,418	277,026	1.935132	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	MENTAL HEALTH CLINIC	0	75,760	75,760	2.579673	0.000000	90.04
90.05	09005	ENT CLINIC	0	16,902	16,902	7.451130	0.000000	90.05
91.00	09100	EMERGENCY	69,186	4,652,722	4,721,908	0.709814	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,871	224,130	240,001	1.251791	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,216,934	2,216,934	0.841804	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	35,023,148	72,680,906	107,704,054			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	35,023,148	72,680,906	107,704,054			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
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
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	08802	RURAL HEALTH CLINIC II				88.01
88.02	08801	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000			90.01
90.02	09002	SURGICAL CLINIC	0.000000			90.02
90.03	09003	OP CLINIC	0.000000			90.03
90.04	09004	MENTAL HEALTH CLINIC	0.000000			90.04
90.05	09005	ENT 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: 14-1327

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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,903,667		3,903,667	0	3,903,667	30.00	
31.00	03100	INTENSIVE CARE UNIT	596,243		596,243	0	596,243	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,511,808		3,511,808	0	3,511,808	50.00	
53.00	05300	ANESTHESIOLOGY	379,046		379,046	0	379,046	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,640,674		2,640,674	0	2,640,674	54.00	
60.00	06000	LABORATORY	3,195,408		3,195,408	0	3,195,408	60.00	
65.00	06500	RESPIRATORY THERAPY	1,247,978	0	1,247,978	0	1,247,978	65.00	
66.00	06600	PHYSICAL THERAPY	2,211,674	0	2,211,674	0	2,211,674	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,553,247		1,553,247	0	1,553,247	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,807,075		2,807,075	0	2,807,075	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,566,207		3,566,207	0	3,566,207	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	430,680		430,680	0	430,680	88.00	
88.01	08802	RURAL HEALTH CLINIC II	2,530,767		2,530,767	0	2,530,767	88.01	
88.02	08801	RURAL HEALTH CLINIC III	1,530,174		1,530,174	0	1,530,174	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	1,260,837		1,260,837	0	1,260,837	88.03	
88.04	08804	RURAL HEALTH CLINIC V	805,293		805,293	0	805,293	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	572,025		572,025	0	572,025	88.05	
90.00	09000	CLINIC	836,764		836,764	0	836,764	90.00	
90.01	09001	ORTHOPAEDIC CLINIC	3,160,978		3,160,978	0	3,160,978	90.01	
90.02	09002	SURGICAL CLINIC	536,082		536,082	0	536,082	90.02	
90.03	09003	OP CLINIC	0		0	0	0	90.03	
90.04	09004	MENTAL HEALTH CLINIC	195,436		195,436	0	195,436	90.04	
90.05	09005	ENT CLINIC	125,939		125,939	0	125,939	90.05	
91.00	09100	EMERGENCY	3,351,677		3,351,677	0	3,351,677	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	300,431		300,431	0	300,431	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,866,225		1,866,225	0	1,866,225	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	43,116,335	0	43,116,335	0	43,116,335	200.00	
201.00		Less Observation Beds	300,431		300,431		300,431	201.00	
202.00		Total (see instructions)	42,815,904	0	42,815,904	0	42,815,904	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

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			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	2,982,498		2,982,498		30.00
31.00	03100	INTENSIVE CARE UNIT	82,203		82,203		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,135,610	8,558,546	18,694,156	0.187856	50.00
53.00	05300	ANESTHESIOLOGY	1,306,680	2,074,139	3,380,819	0.112117	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	713,729	16,682,127	17,395,856	0.151799	54.00
60.00	06000	LABORATORY	1,112,054	14,253,681	15,365,735	0.207957	60.00
65.00	06500	RESPIRATORY THERAPY	280,792	2,463,706	2,744,498	0.454720	65.00
66.00	06600	PHYSICAL THERAPY	1,261,539	5,183,211	6,444,750	0.343175	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,940,209	363,959	3,304,168	0.470087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,494,872	210,000	12,704,872	0.220945	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,624,797	8,066,505	9,691,302	0.367980	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	295,244	295,244	1.458726	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	1,530,650	1,530,650	1.653394	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,051,119	1,051,119	1.455757	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	885,869	885,869	1.423277	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	741,065	741,065	1.086670	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	223,467	223,467	2.559774	88.05
90.00	09000	CLINIC	0	877,600	877,600	0.953469	90.00
90.01	09001	ORTHOPAEDIC CLINIC	500	1,759,152	1,759,652	1.796365	90.01
90.02	09002	SURGICAL CLINIC	2,608	274,418	277,026	1.935132	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	90.03
90.04	09004	MENTAL HEALTH CLINIC	0	75,760	75,760	2.579673	90.04
90.05	09005	ENT CLINIC	0	16,902	16,902	7.451130	90.05
91.00	09100	EMERGENCY	69,186	4,652,722	4,721,908	0.709814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,871	224,130	240,001	1.251791	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,216,934	2,216,934	0.841804	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	35,023,148	72,680,906	107,704,054		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	35,023,148	72,680,906	107,704,054		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
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
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	08802	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08801	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
88.05	08805	RURAL HEALTH CLINIC VI	0.000000			88.05
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000			90.01
90.02	09002	SURGICAL CLINIC	0.000000			90.02
90.03	09003	OP CLINIC	0.000000			90.03
90.04	09004	MENTAL HEALTH CLINIC	0.000000			90.04
90.05	09005	ENT 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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
5/24/2021 3:02 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	564,575	18,694,156	0.030201	6,140,354	185,445	50.00
53.00	05300 ANESTHESIOLOGY	0	3,380,819	0.000000	734,711	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	131,119	17,395,856	0.007537	430,794	3,247	54.00
60.00	06000 LABORATORY	98,831	15,365,735	0.006432	659,983	4,245	60.00
65.00	06500 RESPIRATORY THERAPY	44,308	2,744,498	0.016144	148,729	2,401	65.00
66.00	06600 PHYSICAL THERAPY	191,121	6,444,750	0.029655	620,143	18,390	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	109,643	3,304,168	0.033183	1,239,405	41,127	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	11,350	12,704,872	0.000893	6,552,941	5,852	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	39,669	9,691,302	0.004093	763,930	3,127	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	42,527	295,244	0.144040	0	0	88.00
88.01	08802 RURAL HEALTH CLINIC II	13,642	1,530,650	0.008913	0	0	88.01
88.02	08801 RURAL HEALTH CLINIC III	175,876	1,051,119	0.167323	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	8,883	885,869	0.010027	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	4,865	741,065	0.006565	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	201,397	223,467	0.901238	0	0	88.05
90.00	09000 CLINIC	96,162	877,600	0.109574	0	0	90.00
90.01	09001 ORTHOPAEDIC CLINIC	42,368	1,759,652	0.024077	245	6	90.01
90.02	09002 SURGICAL CLINIC	3,776	277,026	0.013630	0	0	90.02
90.03	09003 OP CLINIC	0	0	0.000000	0	0	90.03
90.04	09004 MENTAL HEALTH CLINIC	36,655	75,760	0.483831	0	0	90.04
90.05	09005 ENT CLINIC	526	16,902	0.031121	0	0	90.05
91.00	09100 EMERGENCY	117,337	4,721,908	0.024849	57	1	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	35,591	240,001	0.148295	6,091	903	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,970,221	102,422,419		17,297,383	264,744	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/24/2021 3:02 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	0
53.00	05300	ANESTHESIOLOGY	379,046	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	0	0
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0
90.02	09002	SURGICAL CLINIC	0	0	0	0	0
90.03	09003	OP CLINIC	0	0	0	0	0
90.04	09004	MENTAL HEALTH CLINIC	0	0	0	0	0
90.05	09005	ENT CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
200.00		Total (lines 50 through 199)	379,046	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/24/2021 3:02 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	18,694,156	0.000000
53.00	05300	ANESTHESIOLOGY	0	379,046	0	3,380,819	0.112117
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,395,856	0.000000
60.00	06000	LABORATORY	0	0	0	15,365,735	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,744,498	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	6,444,750	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,304,168	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	12,704,872	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,691,302	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	295,244	0.000000
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	1,530,650	0.000000
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	1,051,119	0.000000
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	885,869	0.000000
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	741,065	0.000000
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	223,467	0.000000
90.00	09000	CLINIC	0	0	0	877,600	0.000000
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	1,759,652	0.000000
90.02	09002	SURGICAL CLINIC	0	0	0	277,026	0.000000
90.03	09003	OP CLINIC	0	0	0	0	0.000000
90.04	09004	MENTAL HEALTH CLINIC	0	0	0	75,760	0.000000
90.05	09005	ENT CLINIC	0	0	0	16,902	0.000000
91.00	09100	EMERGENCY	0	0	0	4,721,908	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	240,001	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	379,046	0	102,422,419	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/24/2021 3:02 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	6,140,354	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	734,711	82,374	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	430,794	0	0	0
60.00	06000	LABORATORY	0.000000	659,983	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	148,729	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	620,143	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,239,405	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	6,552,941	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	763,930	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
88.01	08802	RURAL HEALTH CLINIC II	0.000000	0	0	0	0
88.02	08801	RURAL HEALTH CLINIC III	0.000000	0	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	0	0	0	0
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	245	0	0	0
90.02	09002	SURGICAL CLINIC	0.000000	0	0	0	0
90.03	09003	OP CLINIC	0.000000	0	0	0	0
90.04	09004	MENTAL HEALTH CLINIC	0.000000	0	0	0	0
90.05	09005	ENT CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	57	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	6,091	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)		17,297,383	82,374	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/24/2021 3:02 pm

			Title XVIII		Hospital		3/24/2021 3:02 pm	
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	0.187856	0	2,102,453	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.112117	0	462,934	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151799	0	6,341,816	0	0	54.00
60.00	06000	LABORATORY	0.207957	0	5,486,088	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.454720	0	945,607	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.343175	0	1,702,424	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470087	0	259,316	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.220945	0	204,382	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367980	0	4,484,972	980	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08802	RURAL HEALTH CLINIC II						88.01
88.02	08801	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.953469	0	397,663	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.796365	0	609,333	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.935132	0	94,770	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	2.579673	0	28,803	0	0	90.04
90.05	09005	ENT CLINIC	7.451130	0	5,768	0	0	90.05
91.00	09100	EMERGENCY	0.709814	0	1,612,230	500	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.251791	0	101,286	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.841804		0			95.00
200.00		Subtotal (see instructions)		0	24,839,845	1,480	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	24,839,845	1,480	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/24/2021 3:02 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	394,958	0		50.00
53.00	05300	ANESTHESIOLOGY	51,903	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,681	0		54.00
60.00	06000	LABORATORY	1,140,870	0		60.00
65.00	06500	RESPIRATORY THERAPY	429,986	0		65.00
66.00	06600	PHYSICAL THERAPY	584,229	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	121,901	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45,157	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,380	361		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08802	RURAL HEALTH CLINIC II				88.01
88.02	08801	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	379,159	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,094,584	0		90.01
90.02	09002	SURGICAL CLINIC	183,392	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
90.04	09004	MENTAL HEALTH CLINIC	74,302	0		90.04
90.05	09005	ENT CLINIC	42,978	0		90.05
91.00	09100	EMERGENCY	1,144,383	355		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	126,789	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	8,427,652	716		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,427,652	716		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/24/2021 3:02 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	0.187856	0	243,054	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.112117	0	61,460	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151799	0	373,610	0	0	54.00
60.00	06000	LABORATORY	0.207957	0	212,918	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.454720	0	19,814	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.343175	0	26,817	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470087	0	96,267	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.220945	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367980	0	90,955	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08802	RURAL HEALTH CLINIC II						88.01
88.02	08801	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.953469	0	2,876	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.796365	0	7,678	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.935132	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	2.579673	0	0	0	0	90.04
90.05	09005	ENT CLINIC	7.451130	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.709814	0	162,265	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.251791	0	7,366	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.841804	0	0			95.00
200.00		Subtotal (see instructions)		0	1,305,080	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,305,080	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/24/2021 3:02 pm

			Title XIX		Hospital	Cost
	Cost Center Description		Costs			
			Cost	Cost		
			Reimbursed	Reimbursed		
			Services	Services Not		
		Subject To	Subject To			
		Ded. & Coins.	Ded. & Coins.			
		(see inst.)	(see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	45,659	0		50.00
53.00	05300	ANESTHESIOLOGY	6,891	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,714	0		54.00
60.00	06000	LABORATORY	44,278	0		60.00
65.00	06500	RESPIRATORY THERAPY	9,010	0		65.00
66.00	06600	PHYSICAL THERAPY	9,203	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,254	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,470	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08802	RURAL HEALTH CLINIC II				88.01
88.02	08801	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	2,742	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	13,792	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
90.04	09004	MENTAL HEALTH CLINIC	0	0		90.04
90.05	09005	ENT CLINIC	0	0		90.05
91.00	09100	EMERGENCY	115,178	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,221	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	391,412	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	391,412	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1327

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

Worksheet D-1

Date/Time Prepared:
5/24/2021 3:02 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)	2,478	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,982	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)	1,799	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	385	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	111	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)	1,174	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)	385	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	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,903,667	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	17,757	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)	649,812	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,253,855	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,253,855	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)	1,641.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,927,356	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,927,356	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1327

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

Worksheet D-1

Date/Time Prepared:
5/24/2021 3:02 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	596,243	68	8,768.28	17	149,061	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)					4,038,650	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,115,067	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)					632,055	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)					632,055	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)					183	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,641.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					300,431	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1327

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

Worksheet D-1

Date/Time Prepared:
5/24/2021 3:02 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	462,455	3,903,667	0.118467	300,431	35,591
91.00	Nursing School cost	0	3,903,667	0.000000	300,431	0
92.00	Allied health cost	0	3,903,667	0.000000	300,431	0
93.00	All other Medical Education	0	3,903,667	0.000000	300,431	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/24/2021 3:02 pm	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,791,760		30.00
31.00	03100	INTENSIVE CARE UNIT		42,347		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.187856	6,140,354	1,153,502	50.00
53.00	05300	ANESTHESIOLOGY	0.112117	734,711	82,374	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151799	430,794	65,394	54.00
60.00	06000	LABORATORY	0.207957	659,983	137,248	60.00
65.00	06500	RESPIRATORY THERAPY	0.454720	148,729	67,630	65.00
66.00	06600	PHYSICAL THERAPY	0.343175	620,143	212,818	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470087	1,239,405	582,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.220945	6,552,941	1,447,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367980	763,930	281,111	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801	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
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.953469	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.796365	245	440	90.01
90.02	09002	SURGICAL CLINIC	1.935132	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
90.04	09004	MENTAL HEALTH CLINIC	2.579673	0	0	90.04
90.05	09005	ENT CLINIC	7.451130	0	0	90.05
91.00	09100	EMERGENCY	0.709814	57	40	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.251791	6,091	7,625	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)		17,297,383	4,038,650	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)		17,297,383		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1327 Component CCN: 14-Z327	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/24/2021 3:02 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.187856	201	38	50.00
53.00	05300 ANESTHESIOLOGY	0.112117	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151799	33,149	5,032	54.00
60.00	06000 LABORATORY	0.207957	74,322	15,456	60.00
65.00	06500 RESPIRATORY THERAPY	0.454720	24,786	11,271	65.00
66.00	06600 PHYSICAL THERAPY	0.343175	256,737	88,106	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470087	67,544	31,752	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.220945	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.367980	156,705	57,664	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801 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
88.05	08805 RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000 CLINIC	0.953469	0	0	90.00
90.01	09001 ORTHOPAEDIC CLINIC	1.796365	0	0	90.01
90.02	09002 SURGICAL CLINIC	1.935132	0	0	90.02
90.03	09003 OP CLINIC	0.000000	0	0	90.03
90.04	09004 MENTAL HEALTH CLINIC	2.579673	0	0	90.04
90.05	09005 ENT CLINIC	7.451130	0	0	90.05
91.00	09100 EMERGENCY	0.709814	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.251791	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)		613,444	209,319	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)		613,444		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/24/2021 3:02 pm
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		29,528	
31.00	03100	INTENSIVE CARE UNIT		0	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.187856	74,403	13,977
53.00	05300	ANESTHESIOLOGY	0.112117	11,457	1,285
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151799	25,042	3,801
60.00	06000	LABORATORY	0.207957	10,327	2,148
65.00	06500	RESPIRATORY THERAPY	0.454720	0	0
66.00	06600	PHYSICAL THERAPY	0.343175	9,671	3,319
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470087	86,888	40,845
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.220945	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.367980	9,052	3,331
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.458726	0	0
88.01	08802	RURAL HEALTH CLINIC II	1.653394	0	0
88.02	08801	RURAL HEALTH CLINIC III	1.455757	0	0
88.03	08803	RURAL HEALTH CLINIC IV	1.423277	0	0
88.04	08804	RURAL HEALTH CLINIC V	1.086670	0	0
88.05	08805	RURAL HEALTH CLINIC VI	2.559774	0	0
90.00	09000	CLINIC	0.953469	0	0
90.01	09001	ORTHOPAEDIC CLINIC	1.796365	0	0
90.02	09002	SURGICAL CLINIC	1.935132	0	0
90.03	09003	OP CLINIC	0.000000	0	0
90.04	09004	MENTAL HEALTH CLINIC	2.579673	0	0
90.05	09005	ENT CLINIC	7.451130	0	0
91.00	09100	EMERGENCY	0.709814	3,321	2,357
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.251791	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50 through 94 and 96 through 98)		230,161	71,063
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	
202.00		Net charges (line 200 minus line 201)		230,161	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/24/2021 3:02 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,428,368	1.00
2.00	Medical and other services reimbursed under OPPIs (see instructions)		0	2.00
3.00	OPPIs 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)		8,428,368	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		8,512,652	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)		80,072	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,856,753	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)		4,575,827	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)		4,575,827	30.00
31.00	Primary payer payments		702	31.00
32.00	Subtotal (line 30 minus line 31)		4,575,125	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)		368,949	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		239,817	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		317,740	36.00
37.00	Subtotal (see instructions)		4,814,942	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)		4,814,942	40.00
40.01	Sequestration adjustment (see instructions)		31,779	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		4,262,206	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)		520,957	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		83,936	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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
5/24/2021 3:02 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		5,050,590		4,262,206	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,050,590		4,262,206	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		684,109		520,957	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,734,699		4,783,163	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: 14-1327

Period:

Worksheet E-1

Component CCN: 14-Z327

From 01/01/2020

Part I

To 12/31/2020

Date/Time Prepared:

5/24/2021 3:02 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		748,840		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		748,840		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		81,527		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		830,367		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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
5/24/2021 3:02 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:14-1327

Period:

Worksheet E-2

Component CCN:14-Z327

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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)		638,376	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)		211,412	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		385	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)		849,788	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		849,788	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)		849,788	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)		835,884	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)		835,884	0	19.00
19.01	Sequestration adjustment (see instructions)		5,517	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		748,840	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)		81,527	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: 14-1327	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 5/24/2021 3:02 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		6,115,067	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)		6,115,067	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		6,176,218	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)		6,176,218	19.00
20.00	Deductibles (exclude professional component)		454,520	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		5,721,698	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		5,721,698	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		78,617	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		51,101	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		66,743	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		5,772,799	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)		5,772,799	30.00
30.01	Sequestration adjustment (see instructions)		38,100	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		5,050,590	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)		684,109	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		17,885	34.00

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

Provider CCN: 14-1327

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

Worksheet G

Date/Time Prepared:
5/24/2021 3:02 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	6,326,746	0	0	0	1.00
2.00	Temporary investments	15,227,129	0	0	0	2.00
3.00	Notes receivable	19,001	0	0	0	3.00
4.00	Accounts receivable	21,725,357	0	0	0	4.00
5.00	Other receivable	93,115	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,827,950	0	0	0	6.00
7.00	Inventory	1,109,380	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,062,783	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)	33,735,561	0	0	0	11.00
FIXED ASSETS						
12.00	Land	562,437	0	0	0	12.00
13.00	Land improvements	2,281,999	0	0	0	13.00
14.00	Accumulated depreciation	-1,395,168	0	0	0	14.00
15.00	Buildings	28,958,345	0	0	0	15.00
16.00	Accumulated depreciation	-12,966,601	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-3,143,522	0	0	0	18.00
19.00	Fixed equipment	5,281,793	0	0	0	19.00
20.00	Accumulated depreciation	-14,101,373	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	17,781,408	0	0	0	23.00
24.00	Accumulated depreciation	1,151,697	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)	24,411,015	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)	58,146,576	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,336,665	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,609,525	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	9,231,727	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	314,188	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,492,105	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,495,000	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)	1,495,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,987,105	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	44,159,471				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)	44,159,471	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,146,576	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1327

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

Worksheet G-1

Date/Time Prepared:
5/24/2021 3:02 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		37,576,907		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,582,564				2.00
3.00	Total (sum of line 1 and line 2)		44,159,471		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)		44,159,471		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)		44,159,471		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: 14-1327

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2021 3:02 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,979,287		3,979,287	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)	3,979,287		3,979,287	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	82,605		82,605	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)	82,605		82,605	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,061,892		4,061,892	17.00
18.00	Ancillary services	33,030,840	74,169,230	107,200,070	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	296,106	296,106	20.00
20.01	RURAL HEALTH CLINIC II	0	1,539,224	1,539,224	20.01
20.02	RURAL HEALTH CLINIC III	0	1,052,131	1,052,131	20.02
20.03	RURAL HEALTH CLINIC IV	0	886,304	886,304	20.03
20.04	RURAL HEALTH CLINIC V	0	741,096	741,096	20.04
20.05	RURAL HEALTH CLINIC VI	0	0	0	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,216,934	2,216,934	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	617,409	617,409	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	37,092,732	81,518,434	118,611,166	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50,155,856		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)		50,155,856		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1327

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

Worksheet G-3

Date/Time Prepared:
5/24/2021 3:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	118,611,166	1.00
2.00	Less contractual allowances and discounts on patients' accounts	69,137,066	2.00
3.00	Net patient revenues (line 1 minus line 2)	49,474,100	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	50,155,856	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-681,756	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	30,266	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	131,039	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	1,349	16.00
17.00	Revenue from sale of drugs to other than patients	412,979	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	847,330	24.00
24.50	COVID-19 PHE Funding	5,437,614	24.50
25.00	Total other income (sum of lines 6-24)	6,860,577	25.00
26.00	Total (line 5 plus line 25)	6,178,821	26.00
27.00	NON-OPERATING G/L	-403,743	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-403,743	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,582,564	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8501

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	172,021	172,021	0	172,021
3.00	Nurse Practitioner	0	0	0	12,204	12,204
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	46,212	46,212
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)	0	172,021	172,021	58,416	230,437
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	9,279	9,279	0	9,279
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	9,279	9,279	0	9,279
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	181,300	181,300	58,416	239,716
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	130	130	0	130
30.00	Administrative Costs	74,396	0	74,396	-56,669	17,727
31.00	Total Facility Overhead (sum of lines 29 and 30)	74,396	130	74,526	-56,669	17,857
32.00	Total facility costs (sum of lines 22, 28 and 31)	74,396	181,430	255,826	1,747	257,573

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8501

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	0	1.00
2.00 Physician Assistant	0	172,021	2.00
3.00 Nurse Practitioner	0	12,204	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	46,212	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	230,437	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	9,279	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	9,279	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	239,716	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	130	29.00
30.00 Administrative Costs	0	17,727	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	0	17,857	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	0	257,573	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8568

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

						RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
FACILITY HEALTH CARE STAFF COSTS									
1.00	Physician	0	0	0	658,702	658,702	1.00		
2.00	Physician Assistant	0	0	0	74,975	74,975	2.00		
3.00	Nurse Practitioner	0	0	0	147,760	147,760	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	261,834	261,834	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	27,859	27,859	9.00		
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	1,171,130	1,171,130	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	43,913	43,913	0	43,913	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						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	43,913	43,913	0	43,913	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	43,913	43,913	1,171,130	1,215,043	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	2,274	2,274	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						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	2,274	2,274	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	13,718	13,718	0	13,718	29.00		
30.00	Administrative Costs	1,529,515	97,099	1,626,614	-1,173,404	453,210	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,529,515	110,817	1,640,332	-1,173,404	466,928	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,529,515	154,730	1,684,245	0	1,684,245	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8568

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	658,702	1.00
2.00	Physician Assistant	0	74,975	2.00
3.00	Nurse Practitioner	0	147,760	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	261,834	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	27,859	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,171,130	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	43,913	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	43,913	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,215,043	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	2,274	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	2,274	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	13,718	29.00
30.00	Administrative Costs	0	453,210	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	466,928	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,684,245	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8579

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

						RHC III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
FACILITY HEALTH CARE STAFF COSTS									
1.00	Physician	0	0	0	350,209	350,209	1.00		
2.00	Physician Assistant	0	0	0	79,993	79,993	2.00		
3.00	Nurse Practitioner	0	0	0	52,002	52,002	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	79,808	79,808	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	50,206	50,206	9.00		
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	612,218	612,218	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	12,970	12,970	0	12,970	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						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	12,970	12,970	0	12,970	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	12,970	12,970	612,218	625,188	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	6,923	6,923	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						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	6,923	6,923	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	7,703	7,703	0	7,703	29.00		
30.00	Administrative Costs	801,638	18,029	819,667	-619,141	200,526	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	801,638	25,732	827,370	-619,141	208,229	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	801,638	38,702	840,340	0	840,340	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8579

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	350,209	1.00
2.00	Physician Assistant	0	79,993	2.00
3.00	Nurse Practitioner	0	52,002	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	79,808	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	50,206	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	612,218	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	12,970	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	12,970	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	625,188	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	6,923	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	6,923	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	7,703	29.00
30.00	Administrative Costs	0	200,526	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	208,229	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	840,340	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8599

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

						RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
FACILITY HEALTH CARE STAFF COSTS									
1.00	Physician	0	0	0	247,602	247,602	1.00		
2.00	Physician Assistant	0	0	0	134,033	134,033	2.00		
3.00	Nurse Practitioner	0	0	0	26,787	26,787	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	166,671	166,671	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00		
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	575,093	575,093	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	27,495	27,495	0	27,495	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						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	27,495	27,495	0	27,495	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	27,495	27,495	575,093	602,588	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	3,708	3,708	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						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	3,708	3,708	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	9,576	9,576	0	9,576	29.00		
30.00	Administrative Costs	742,964	17,406	760,370	-578,801	181,569	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	742,964	26,982	769,946	-578,801	191,145	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	742,964	54,477	797,441	0	797,441	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8599

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	247,602
2.00	Physician Assistant	0	134,033
3.00	Nurse Practitioner	0	26,787
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	166,671
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	575,093
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	27,495
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	27,495
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	602,588
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	3,708
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,708
FACILITY OVERHEAD			
29.00	Facility Costs	0	9,576
30.00	Administrative Costs	0	181,569
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	191,145
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	797,441

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8601

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

		RHC V		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	116,969	116,969
2.00	Physician Assistant	0	0	0	26,499	26,499
3.00	Nurse Practitioner	0	0	0	119,880	119,880
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	135,686	135,686
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)	0	0	0	399,034	399,034
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	16,917	16,917	0	16,917
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	16,917	16,917	0	16,917
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	16,917	16,917	399,034	415,951
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	172	172
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	172	172
FACILITY OVERHEAD						
29.00	Facility Costs	0	23,664	23,664	0	23,664
30.00	Administrative Costs	482,178	4,814	486,992	-400,953	86,039
31.00	Total Facility Overhead (sum of lines 29 and 30)	482,178	28,478	510,656	-400,953	109,703
32.00	Total facility costs (sum of lines 22, 28 and 31)	482,178	45,395	527,573	-1,747	525,826

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8601

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	116,969	1.00
2.00	Physician Assistant	0	26,499	2.00
3.00	Nurse Practitioner	0	119,880	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	135,686	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	399,034	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	16,917	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	16,917	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	415,951	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	172	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	172	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	23,664	29.00
30.00	Administrative Costs	0	86,039	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	109,703	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	525,826	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8613

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

		RHC VI		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	2,900	2,900
3.00	Nurse Practitioner	0	0	0	64,046	64,046
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	58,238	58,238
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	20,724	20,724
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	145,908	145,908
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	0	0	9,890	9,890
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	9,890	9,890
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	155,798	155,798
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	215	215
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	215	215
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	721	721
30.00	Administrative Costs	0	0	0	70,991	70,991
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	71,712	71,712
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	227,725	227,725

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8613

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC VI	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	2,900		2.00
3.00	Nurse Practitioner	0	64,046		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	58,238		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	20,724		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	145,908		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	9,890		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	9,890		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	155,798		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	215		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	215		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	721		29.00
30.00	Administrative Costs	0	70,991		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	71,712		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	227,725		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8501

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	0.00	0	1	0
2.00	Physician Assistant	0.44	1,334	1	0
3.00	Nurse Practitioner	0.42	1,011	1	0
4.00	Subtotal (sum of lines 1 through 3)	0.86	2,345	0	2,345
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)	0.86	2,345		2,345
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)				239,716
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				239,716
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				17,857
15.00	Parent provider overhead allocated to facility (see instructions)				173,107
16.00	Total overhead (sum of lines 14 and 15)				190,964
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				190,964
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				190,964
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				430,680

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8568

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	2.33	4,757	1	2
2.00	Physician Assistant	0.66	551	1	1
3.00	Nurse Practitioner	0.96	1,374	1	1
4.00	Subtotal (sum of lines 1 through 3)	3.95	6,682		4
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)	3.95	6,682		6,682
9.00	Physician Services Under Agreements		50		50
					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)				1,215,043
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				2,274
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,217,317
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.998132
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				466,928
15.00	Parent provider overhead allocated to facility (see instructions)				846,522
16.00	Total overhead (sum of lines 14 and 15)				1,313,450
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				1,313,450
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,310,996
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,526,039

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8579

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	0.94	4,683	1	1
2.00	Physician Assistant	0.41	1,153	1	0
3.00	Nurse Practitioner	0.36	1,025	1	0
4.00	Subtotal (sum of lines 1 through 3)	1.71	6,861	1	6,861
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)	1.71	6,861		6,861
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)				625,188
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				6,923
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				632,111
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.989048
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				208,229
15.00	Parent provider overhead allocated to facility (see instructions)				689,834
16.00	Total overhead (sum of lines 14 and 15)				898,063
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				898,063
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				888,227
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,513,415

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8599

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	1.04	3,011	1	1.00
2.00	Physician Assistant	0.92	3,539	1	2.00
3.00	Nurse Practitioner	0.26	139	1	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.22	6,689	2	4.00
5.00	Visiting Nurse	0.00	0		5.00
6.00	Clinical Psychologist	0.00	0		6.00
7.00	Clinical Social Worker	0.00	0		7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.22	6,689		8.00
9.00	Physician Services Under Agreements		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)			602,588	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)			3,708	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)			606,296	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)			0.993884	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)			191,145	14.00
15.00	Parent provider overhead allocated to facility (see instructions)			463,396	15.00
16.00	Total overhead (sum of lines 14 and 15)			654,541	16.00
17.00	Allowable GME overhead (see instructions)			0	17.00
18.00	Enter the amount from line 16			654,541	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)			650,538	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)			1,253,126	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8601

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 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	0.25	1,062	1	0
2.00	Physician Assistant	0.22	209	1	0
3.00	Nurse Practitioner	0.83	1,590	1	1
4.00	Subtotal (sum of lines 1 through 3)	1.30	2,861	1	2,861
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)	1.30	2,861		2,861
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)				415,951
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				172
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				416,123
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.999587
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				109,703
15.00	Parent provider overhead allocated to facility (see instructions)				279,467
16.00	Total overhead (sum of lines 14 and 15)				389,170
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				389,170
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				389,009
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				804,960

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8613

From 01/01/2020
To 12/31/2020Date/Time Prepared:
5/24/2021 3:02 pm

		RHC VI		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	0.02	27	1	0
3.00	Nurse Practitioner	0.46	1,358	1	0
4.00	Subtotal (sum of lines 1 through 3)	0.48	1,385	0	1,385
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)	0.48	1,385		1,385
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)				155,798
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				215
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				156,013
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.998622
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				71,712
15.00	Parent provider overhead allocated to facility (see instructions)				344,300
16.00	Total overhead (sum of lines 14 and 15)				416,012
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				416,012
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				415,439
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				571,237

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1327 Component CCN:14-8501	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 5/24/2021 3:02 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)			430,680	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			430,680	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,345	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)			2,345	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			183.66	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)			183.66	183.66	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	198	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	36,365	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	36,365	16.00
16.01	Total program charges (see instructions)(from contractor's records)				25,700	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.)				24,186	16.04
16.05	Total program cost (see instructions)			0	24,186	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				6,133	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				3,914	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				24,186	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				24,186	22.00
23.00	Allowable bad debts (see instructions)				191	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				124	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				68	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)				24,310	26.00
26.01	Sequestration adjustment (see instructions)				160	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				12,217	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)				11,933	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8568	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 5/24/2021 3:02 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)			2,526,039	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			138,451	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,387,588	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,682	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			50	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			6,732	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			354.66	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)			354.66	354.66	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,531	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	542,984	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	542,984	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			222,823	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			30,066	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			73,266	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.)			351,723	16.04	
16.05	Total program cost (see instructions)		0	424,989	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			30,064	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			32,537	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			424,989	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			39,073	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			464,062	22.00	
23.00	Allowable bad debts (see instructions)			840	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			546	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)			464,608	26.00	
26.01	Sequestration adjustment (see instructions)			3,066	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			213,029	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)			248,513	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8579	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 5/24/2021 3:02 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)			1,513,415	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			71,908	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,441,507	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,861	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)			6,861	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			210.10	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)			210.10	210.10	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,359	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	705,726	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	705,726	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			490,327	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			6,861	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			9,875	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.)			512,026	16.04	
16.05	Total program cost (see instructions)		0	521,901	16.05	
17.00	Primary payer amounts			107	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			55,818	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			85,527	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			521,794	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			45,456	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			567,250	22.00	
23.00	Allowable bad debts (see instructions)			2,060	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			1,339	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)			568,589	26.00	
26.01	Sequestration adjustment (see instructions)			3,753	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			407,546	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)			157,290	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1327 Component CCN:14-8599	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 5/24/2021 3:02 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)			1,253,126	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			25,384	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,227,742	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,689	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)			6,689	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			183.55	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)		183.55	183.55	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,433	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	446,577	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	446,577	16.00
16.01	Total program charges (see instructions)(from contractor's records)			313,462	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			19,548	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			27,849	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.)			293,872	16.04
16.05	Total program cost (see instructions)		0	321,721	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			51,388	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			48,502	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			321,721	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			13,998	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			335,719	22.00
23.00	Allowable bad debts (see instructions)			70	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			46	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)			335,765	26.00
26.01	Sequestration adjustment (see instructions)			2,216	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			206,378	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)			127,171	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8601	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 5/24/2021 3:02 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)			804,960	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			27,933	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			777,027	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,861	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)			2,861	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			271.59	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)			271.59	271.59	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	811	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	220,259	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	220,259	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			118,144	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			14,345	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			26,744	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.)			145,010	16.04	
16.05	Total program cost (see instructions)		0	171,754	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			12,253	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			18,309	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			171,754	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,747	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			182,501	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)			182,501	26.00	
26.01	Sequestration adjustment (see instructions)			1,205	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			151,096	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)			30,200	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8613	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 5/24/2021 3:02 pm		
		Title XVIII	RHC VI	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)			571,237	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			46,700	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			524,537	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,385	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			1,385	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			378.73	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)			378.73	378.73	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	585	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	221,557	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	221,557	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			79,245	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			3,995	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			11,169	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.)			166,115	16.04	
16.05	Total program cost (see instructions)		0	177,284	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			2,744	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			14,500	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			177,284	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			33,468	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			210,752	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)			210,752	26.00	
26.01	Sequestration adjustment (see instructions)			1,391	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			21,149	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)			188,212	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:14-1327 Component CCN:14-8568	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 5/24/2021 3:02 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)		1,171,130	1,171,130	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.004889	0.011948	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		5,726	13,993	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		39,420	7,457	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		45,146	21,450	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,215,043	1,215,043	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,310,996	1,310,996	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.037156	0.017654	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		48,711	23,144	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		93,857	44,594	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		241	589	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		389.45	75.71	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		77	120	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		29,988	9,085	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)			138,451	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)			39,073	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1327 Component CCN:14-8579	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 5/24/2021 3:02 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)		612,218	612,218	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003420	0.017758	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,094	10,872	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		11,941	4,798	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		14,035	15,670	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		625,188	625,188	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		888,227	888,227	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.022449	0.025064	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		19,940	22,263	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		33,975	37,933	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		73	379	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		465.41	100.09	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		51	217	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		23,736	21,720	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)			71,908	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)			45,456	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1327 Component CCN:14-8599	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 5/24/2021 3:02 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)		575,093	575,093	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000970	0.007798	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		558	4,485	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		4,416	2,747	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,974	7,232	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		602,588	602,588	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		650,538	650,538	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008254	0.012002	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		5,370	7,808	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		10,344	15,040	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		27	217	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		383.11	69.31	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		17	108	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		6,513	7,485	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			25,384	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)			13,998	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1327 Component CCN: 14-8601	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 5/24/2021 3:02 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)		399,034	399,034	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002959	0.008937	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,181	3,566	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		7,851	1,836	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		9,032	5,402	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		415,951	415,951	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		389,009	389,009	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.021714	0.012987	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,447	5,052	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		17,479	10,454	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		48	145	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		364.15	72.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		21	43	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		7,647	3,100	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)			27,933	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)			10,747	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1327 Component CCN:14-8613	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 5/24/2021 3:02 pm	
		Title XVIII	RHC VI	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		145,908	145,908	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.004342	0.035404	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		634	5,166	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		4,253	2,684	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,887	7,850	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		155,798	155,798	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		415,439	415,439	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.031368	0.050386	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		13,031	20,932	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		17,918	28,782	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		26	212	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		689.15	135.76	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		20	145	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		13,783	19,685	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)			46,700	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)			33,468	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 5/24/2021 3:02 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			12,217	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			12,217	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			11,933	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			24,150	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:14-1327 Component CCN:14-8568	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 5/24/2021 3:02 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			213,029	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			213,029	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			248,513	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			461,542	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:14-1327 Component CCN:14-8579	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 5/24/2021 3:02 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			407,546	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			407,546	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			157,290	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			564,836	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: 14-1327 Component CCN: 14-8599	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 5/24/2021 3:02 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			206,378	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			206,378	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			127,171	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			333,549	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: 14-1327 Component CCN: 14-8601	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 5/24/2021 3:02 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		151,096	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		151,096	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		30,200	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		181,296	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: 14-1327 Component CCN: 14-8613	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 5/24/2021 3:02 pm	
			RHC VI	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			21,149	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			21,149	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			188,212	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			209,361	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00