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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/28/2020 10:03 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/28/2020 Time: 10:03 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PUTNAM COUNTY HOSPITAL (15-1333) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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) JASON JOHNSON
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-418,590	-563,775	0	-45,768	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	-52,515	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	PUTNAM PEDIATRICS AND INTERNAL MED	0		32,442		0	10.00
10.01	FAMILY MEDICINE OF CLOVERDALE II	0		71,659		0	10.01
10.02	NORTH PUTNAM FAMILY HEALTHCARE III	0		2,781		0	10.02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-471,105	-456,893	0	-45,768	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:03 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1542 SOUTH BLOOMINGTON ST	PO Box:			1.00
2.00	City: GREENCASTLE	State: IN	Zip Code: 46135-	County: PUTNAM	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PUTNAM COUNTY HOSPITAL	151333	26900	1	12/31/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PUTNAM COUNTY HOSPITAL	15Z333	26900		12/31/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	PPIM	158515	26900		02/23/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	FMC	158513	26900		02/25/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	NPFH	158514	26900		03/17/2015	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	9		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			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.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 8/28/2020 10:03 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		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.	1		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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:03 am

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 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 adjustement? 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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:03 am

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:03 am

		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	Y	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)	Y		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

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				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.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				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.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	217,630	2,282	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N			122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:03 am

		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)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		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: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 10:03 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 8/28/2020 10:03 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/18/2020	Y	03/18/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 10:03 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	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.	Y	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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 10:03 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2020 10:03 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	19	6,935	45,816.00	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)		19	6,935	45,816.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	9,312.00	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	55,128.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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
25.10	CMHC - CORF	99.10				0	25.10
26.00	PUTNAM PEDIATRICS AND INTERNAL MED	88.00				0	26.00
26.01	FAMILY MEDICINE OF CLOVERDALE	88.01				0	26.01
26.02	NORTH PUTNAM FAMILY HEALTHCARE	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2020 10:03 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,078	49	1,909			1.00
2.00	HMO and other (see instructions)	0	29				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	309	0	335			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	69			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,387	49	2,313			7.00
8.00	INTENSIVE CARE UNIT	196	0	388			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		0	0			13.00
14.00	Total (see instructions)	1,583	49	2,701	0.00	283.69	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	PUTNAM PEDIATRICS AND INTERNAL MED	1,084	3,130	9,278	0.00	15.64	26.00
26.01	FAMILY MEDICINE OF CLOVERDALE	1,657	2,896	9,552	0.00	16.14	26.01
26.02	NORTH PUTNAM FAMILY HEALTHCARE	1,353	1,989	6,665	0.00	13.29	26.02
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	328.76	27.00
28.00	Observation Bed Days		0	1,308			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2020 10:03 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	375	13	772	1.00
2.00	HMO and other (see instructions)			0	4		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	375	13	772	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	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
25.10	CMHC - CORF	0.00					25.10
26.00	PUTNAM PEDIATRICS AND INTERNAL MED	0.00					26.00
26.01	FAMILY MEDICINE OF CLOVERDALE	0.00					26.01
26.02	NORTH PUTNAM FAMILY HEALTHCARE	0.00					26.02
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: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 8/28/2020 10:03 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1542 S. BLOOMINGTON STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GREENCASTLE		IN	46135	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	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		PUTNAM				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: 15-1333
Component CCN: 15-8515

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

Worksheet S-8
Date/Time Prepared:
8/28/2020 10:03 am

RHC I

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 8/28/2020 10:03 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			51 E. MARKET STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CLOVERDALE		IN	46120	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	18:00	08:00	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?		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		PUTNAM				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	18:00	08:00	18:00	08:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1333
Component CCN: 15-8513

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

Worksheet S-8
Date/Time Prepared:
8/28/2020 10:03 am

RHC II

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	18:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 8/28/2020 10:03 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			440 E. PAT RADY WAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BAINBRIDGE		IN	46105	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	11.00

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		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		PUTNAM				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: 15-1333
Component CCN: 15-8514

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

Worksheet S-8
Date/Time Prepared:
8/28/2020 10:03 am

RHC III

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/28/2020 10:03 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.332267	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,261,265	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	17,795,923	6.00
7.00	Medicaid cost (line 1 times line 6)	5,912,998	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)	2,651,733	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)	2,651,733	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)	2,164,607	0	2,164,607	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	719,227	0	719,227	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)	719,227	0	719,227	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)	3,582,783	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	572,665	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	881,023	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,701,760	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,206,064	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,925,291	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,577,024	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		2,279,318	2,279,318	520,545	2,799,863	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	53,188	5,146,768	5,199,956	0	5,199,956	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,636,404	5,962,352	8,598,756	-116,344	8,482,412	5.00
7.00	00700	OPERATION OF PLANT	322,811	1,055,720	1,378,531	41,785	1,420,316	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,534	164,168	192,702	0	192,702	8.00
9.00	00900	HOUSEKEEPING	424,432	96,617	521,049	0	521,049	9.00
10.00	01000	DIETARY	377,984	585,524	963,508	-673,154	290,354	10.00
11.00	01100	CAFETERIA	0	0	0	673,154	673,154	11.00
13.00	01300	NURSING ADMINISTRATION	77,109	46,702	123,811	0	123,811	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	257,071	161,309	418,380	0	418,380	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	75,456	6,691	82,147	0	82,147	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,899,350	182,631	2,081,981	0	2,081,981	30.00
31.00	03100	INTENSIVE CARE UNIT	647,255	267,522	914,777	0	914,777	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	676,029	1,643,563	2,319,592	23,929	2,343,521	50.00
51.00	05100	RECOVERY ROOM	106,543	35,738	142,281	0	142,281	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	832,046	107,291	939,337	0	939,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	975,699	396,419	1,372,118	0	1,372,118	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	131,744	131,744	0	131,744	54.01
54.02	03480	ONCOLOGY	323,400	3,190,212	3,513,612	0	3,513,612	54.02
57.00	05700	CT SCAN	174,884	231,273	406,157	0	406,157	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	754,007	1,455,252	2,209,259	0	2,209,259	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	378,253	76,869	455,122	0	455,122	65.00
66.00	06600	PHYSICAL THERAPY	0	616,451	616,451	0	616,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	97,782	97,782	0	97,782	67.00
68.00	06800	SPEECH PATHOLOGY	0	49,904	49,904	0	49,904	68.00
69.00	06900	ELECTROCARDIOLOGY	71,908	90,890	162,798	0	162,798	69.00
69.01	06901	CARDIAC REHAB	260,295	13,274	273,569	0	273,569	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,527	46,760	59,287	-59,287	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	35,358	35,358	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,539	793,094	1,065,633	0	1,065,633	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	1,350,853	414,585	1,765,438	-98,162	1,667,276	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	1,119,240	365,784	1,485,024	-123,029	1,361,995	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	969,591	356,455	1,326,046	-77,765	1,248,281	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	373,634	69,664	443,298	0	443,298	90.01
91.00	09100	EMERGENCY	3,071,549	1,149,376	4,220,925	0	4,220,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,522,591	27,287,702	45,810,293	147,030	45,957,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,248,382	929,192	4,177,574	-144,558	4,033,016	192.00
192.01	19201	JOHNSON/NICHOLS WIC	298,663	47,469	346,132	-2,472	343,660	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	0	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	22,069,636	28,264,363	50,333,999	0	50,333,999	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-153,427	2,646,436		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,429	5,194,527		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,419,581	6,062,831		5.00
7.00	00700	OPERATION OF PLANT	-8,160	1,412,156		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	192,702		8.00
9.00	00900	HOUSEKEEPING	0	521,049		9.00
10.00	01000	DIETARY	0	290,354		10.00
11.00	01100	CAFETERIA	-67,980	605,174		11.00
13.00	01300	NURSING ADMINISTRATION	0	123,811		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-747	417,633		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
17.01	01701	UTILIZATION REVIEW	0	82,147		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-810,132	1,271,849		30.00
31.00	03100	INTENSIVE CARE UNIT	0	914,777		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,343,521		50.00
51.00	05100	RECOVERY ROOM	0	142,281		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-710,893	228,444		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,372,118		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	131,744		54.01
54.02	03480	ONCOLOGY	-2,943	3,510,669		54.02
57.00	05700	CT SCAN	0	406,157		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,209,259		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	455,122		65.00
66.00	06600	PHYSICAL THERAPY	0	616,451		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	97,782		67.00
68.00	06800	SPEECH PATHOLOGY	0	49,904		68.00
69.00	06900	ELECTROCARDIOLOGY	0	162,798		69.00
69.01	06901	CARDIAC REHAB	-609	272,960		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	35,358		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-35,966	1,029,667		73.00
73.01	03950	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	-9,226	1,658,050		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	-835	1,361,160		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	-8,714	1,239,567		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	RHEUMATOLOGY	-270,341	172,957		90.01
91.00	09100	EMERGENCY	-2,136,505	2,084,420		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,641,488	39,315,835		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,033,016		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	343,660		192.01
192.02	19203	RHEUMATOLOGY	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	DME	0	0		193.01
193.02	19302	LACTATION CONSULTING	0	0		193.02
193.03	19303	DIABETIC COUNSELING	0	0		193.03
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	0		194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0		194.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
200.00	TOTAL (SUM OF LINES 118 through 199)	-6,641,488	43,692,511		200.00

RECLASSIFICATIONS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/28/2020 10:03 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CLINIC RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	399,396		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,106		2.00
3.00	OPERATION OF PLANT	7.00	0	41,785		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	444,287		
	C - CAFE RECLASS					
1.00	CAFETERIA	11.00	264,078	409,076		1.00
	TOTALS		264,078	409,076		
	D - INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	107,042		1.00
	TOTALS		0	107,042		
	E - PPO DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	14,107		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
	TOTALS		0	14,107		
	F - IMPLANTABLES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	35,358		1.00
	TOTALS		0	35,358		
	G - MED SUPPLY COST RECLASS					
1.00	OPERATING ROOM	50.00	12,527	46,760		1.00
	TOTALS		12,527	46,760		
	H - RHC PHYSICIAN SALARY RECLASS					
1.00	NORTH PUTNAM FAMILY HEALTHCARE	88.02	10,656	0		1.00
	TOTALS		10,656	0		
500.00	Grand Total: Increases		287,261	1,056,630		500.00

RECLASSIFICATIONS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 8/28/2020 10:03 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CLINIC RECLASS						
1.00	PUTNAM PEDIATRICS AND INTERNAL MED	88.00	0	94,978	9		1.00
2.00	FAMILY MEDICINE OF CLOVERDALE	88.01	0	108,318	0		2.00
3.00	NORTH PUTNAM FAMILY HEALTHCARE	88.02	0	87,328	0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	141,255	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	12,408	0		5.00
	TOTALS		0	444,287			
	C - CAFE RECLASS						
1.00	DIETARY	10.00	264,078	409,076	0		1.00
	TOTALS		264,078	409,076			
	D - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	107,042	12		1.00
	TOTALS		0	107,042			
	E - PPO DEPRECIATION						
1.00	PUTNAM PEDIATRICS AND INTERNAL MED	88.00	0	3,184	9		1.00
2.00	FAMILY MEDICINE OF CLOVERDALE	88.01	0	4,055	0		2.00
3.00	NORTH PUTNAM FAMILY HEALTHCARE	88.02	0	1,093	0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,303	0		4.00
5.00	JOHNSON/NICHOLS WIC	192.01	0	2,472	0		5.00
	TOTALS		0	14,107			
	F - IMPLANTABLES						
1.00	OPERATING ROOM	50.00	0	35,358	0		1.00
	TOTALS		0	35,358			
	G - MED SUPPLY COST RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	12,527	46,760	0		1.00
	TOTALS		12,527	46,760			
	H - RHC PHYSICIAN SALARY RECLASS						
1.00	FAMILY MEDICINE OF CLOVERDALE	88.01	10,656	0	0		1.00
	TOTALS		10,656	0			
500.00	Grand Total: Decreases		287,261	1,056,630			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 8/28/2020 10:03 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	159,364	23,138	0	23,138	0	1.00
2.00	Land Improvements	341,824	27,330	0	27,330	0	2.00
3.00	Buildings and Fixtures	32,677,578	499,310	0	499,310	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	24,299,651	291,279	0	291,279	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,478,417	841,057	0	841,057	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	57,478,417	841,057	0	841,057	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	182,502	0	1.00
2.00	Land Improvements	369,154	0	2.00
3.00	Buildings and Fixtures	33,176,888	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	24,590,930	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	58,319,474	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	58,319,474	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,279,318	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	2,279,318	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	2,279,318		1.00
3.00	Total (sum of lines 1-2)	0	2,279,318		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	33,176,888	0	33,176,888	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	33,176,888	0	33,176,888	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,692,821	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,692,821	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-153,427	107,042	0	0	2,646,436	1.00
3.00	Total (sum of lines 1-2)	-153,427	107,042	0	0	2,646,436	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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 - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-3,909,661			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-67,980	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	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	UTILIZATION REVIEW-SNF	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 - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MEDICAL RECORDS FEES	B	-747	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
33.02	CARDIAC REHAB OTHER MISC INCOM	B	-142	CARDIAC REHAB	69.01	0	33.02
33.03	ADVERTISING OFFSET	A	-3,073	RHEUMATOLOGY	90.01	0	33.03
33.04	PHARM - MISC REVENUE	B	-714	DRUGS CHARGED TO PATIENTS	73.00	0	33.04
33.05	VEND REBATE/REF	B	-7,137	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PHARMACY REBATES	B	-35,252	DRUGS CHARGED TO PATIENTS	73.00	0	33.06
33.07	OTHER MISC INCOME	B	-19,515	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	NON-ALLOWABLE INTEREST EXPENSE	A	-37,130	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.08
33.09	LOBBYING OFFSET	A	-906	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTISING OFFSET	A	-33,605	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	ADVERTISING OFFSET	A	-467	CARDIAC REHAB	69.01	0	33.11
33.12	ADVERTISING OFFSET	A	-2,943	ONCOLOGY	54.02	0	33.12
33.13	ADVERTISING OFFSET	A	-9,226	PUTNAM PEDIATRICS AND INTERNAL MED	88.00	0	33.13
33.14	ADVERTISING OFFSET	A	-8,714	NORTH PUTNAM FAMILY HEALTHCARE	88.02	0	33.14
33.15	ADVERTISING OFFSET	A	-835	FAMILY MEDICINE OF CLOVERDALE	88.01	0	33.15
33.16	COMMUNITY RELATIONS OFFSET	A	-155,268	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	COMMUNITY RELATIONS OFFSET	A	-5,203	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.19	TELEPHONE WAGES	A	-938	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	TELEPHONE BENEFITS	A	-226	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	TELEPHONE OTHER	A	-1,031	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	TELEVISION OFFSET	A	-8,160	OPERATION OF PLANT	7.00	0	33.22
33.24	PHYSICIAN RECRUITMENT	A	-519	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	PHYSICIAN RECRUITMENT	A	-15,000	RHEUMATOLOGY	90.01	0	33.27
33.28	PHYSICIAN RECRUITMENT	A	-137	EMERGENCY	91.00	0	33.28
33.29	HAF EXPENSE	A	-2,200,662	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	INTEREST INCOME	B	-116,297	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.30
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,641,488				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 8/28/2020 10:03 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,492,321	2,136,368	355,953	0	0	1.00
2.00	54.01	NUCLEAR MEDICINE-DIAGNOSTIC	128,625	0	128,625	0	0	2.00
3.00	60.00	LABORATORY	32,000	0	32,000	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	832,046	710,893	121,153	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	810,132	810,132	0	0	0	5.00
6.00	90.01	RHEUMATOLOGY	252,268	252,268	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,547,392	3,909,661	637,731		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	90.01	RHEUMATOLOGY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	2,136,368		1.00
2.00	54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	710,893		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	810,132		5.00
6.00	90.01	RHEUMATOLOGY	0	0	0	252,268		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,909,661		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/28/2020 10:03 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					303	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					244	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,666.00	3,192.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	84.94	63.70	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.47	42.47	31.85			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					311,390	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					203,330	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					514,720	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					514,720	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					514,720	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					12,868	24.00
25.00	Assistants (line 4 times column 3, line 11)					7,771	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					20,639	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					20,639	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					20,639	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/28/2020 10:03 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.94	63.70	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	514,720		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	20,639		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	535,359		63.00
64.00	Total cost of outside supplier services (from your records)	525,288		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	20,639		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	20,639		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/28/2020 10:03 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		253	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,652.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.52	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.26	40.26	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	133,019	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	133,019	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	133,019	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	133,019	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	10,186	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	10,186	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	10,186	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	10,186	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/28/2020 10:03 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.52	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		133,019	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		10,186	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		143,205	63.00
64.00	Total cost of outside supplier services (from your records)		97,662	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		10,186	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		10,186	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

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		Speech Pathology	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		161	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,000.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.39	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.70	38.70	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		77,390	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		77,390	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		77,390	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		77,390	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		6,231	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		6,231	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		6,231	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		6,231	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/28/2020 10:03 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.39	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	77,390		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	6,231		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	83,621		63.00
64.00	Total cost of outside supplier services (from your records)	49,754		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	6,231		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,231		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,646,436	2,646,436				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,194,527	3,942	5,198,469			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,062,831	366,429	622,502	7,051,762	7,051,762	5.00
7.00	00700	OPERATION OF PLANT	1,412,156	266,537	76,221	1,754,914	337,745	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192,702	17,417	6,737	216,856	41,735	8.00
9.00	00900	HOUSEKEEPING	521,049	16,283	100,216	637,548	122,701	9.00
10.00	01000	DIETARY	290,354	90,100	26,895	407,349	78,397	10.00
11.00	01100	CAFETERIA	605,174	41,327	62,354	708,855	136,424	11.00
13.00	01300	NURSING ADMINISTRATION	123,811	17,134	18,207	159,152	30,630	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	417,633	101,823	60,699	580,155	111,655	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	82,147	8,580	17,817	108,544	20,890	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,271,849	153,043	448,471	1,873,363	360,542	30.00
31.00	03100	INTENSIVE CARE UNIT	914,777	73,198	152,829	1,140,804	219,556	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,343,521	210,782	162,580	2,716,883	522,883	50.00
51.00	05100	RECOVERY ROOM	142,281	59,130	25,157	226,568	43,605	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	228,444	0	196,461	424,905	81,776	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,372,118	78,093	230,380	1,680,591	323,442	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	131,744	3,607	0	135,351	26,049	54.01
54.02	03480	ONCOLOGY	3,510,669	125,140	76,361	3,712,170	714,433	54.02
57.00	05700	CT SCAN	406,157	34,010	41,293	481,460	92,660	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,209,259	64,670	178,035	2,451,964	471,898	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	455,122	18,035	89,312	562,469	108,251	65.00
66.00	06600	PHYSICAL THERAPY	616,451	43,903	0	660,354	127,090	66.00
67.00	06700	OCCUPATIONAL THERAPY	97,782	0	0	97,782	18,819	67.00
68.00	06800	SPEECH PATHOLOGY	49,904	0	0	49,904	9,604	68.00
69.00	06900	ELECTROCARDIOLOGY	162,798	2,576	16,979	182,353	35,095	69.00
69.01	06901	CARDIAC REHAB	272,960	41,636	61,460	376,056	72,375	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	35,358	0	0	35,358	6,805	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,029,667	23,085	64,351	1,117,103	214,994	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	1,658,050	124,599	318,961	2,101,610	404,470	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	1,361,160	64,283	261,757	1,687,200	324,713	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	1,239,567	145,674	231,454	1,616,695	311,144	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	4,174	0	4,174	803	90.00
90.01	09001	RHEUMATOLOGY	172,957	12,135	88,222	273,314	52,601	90.01
91.00	09100	EMERGENCY	2,084,420	149,591	725,248	2,959,259	569,530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,315,835	2,360,936	4,360,959	38,192,825	5,993,315	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,290	0	12,290	2,365	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,033,016	255,355	766,990	5,055,361	972,934	192.00
192.01	19201	JOHNSON/NICHOLS WIC	343,660	0	70,520	414,180	79,712	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	17,855	0	17,855	3,436	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,692,511	2,646,436	5,198,469	43,692,511	7,051,762	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,092,659					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,138	276,729				8.00
9.00	00900	HOUSEKEEPING	16,957	1,553	778,759			9.00
10.00	01000	DIETARY	93,827	1,147	36,706	617,426		10.00
11.00	01100	CAFETERIA	43,036	0	16,836	0	905,151	11.00
13.00	01300	NURSING ADMINISTRATION	17,842	0	6,980	0	3,435	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	106,035	0	41,482	0	43,548	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	8,935	0	3,495	0	6,260	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,374	60,200	62,349	513,133	130,066	30.00
31.00	03100	INTENSIVE CARE UNIT	76,226	46,486	29,821	104,293	57,845	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219,502	39,335	85,872	0	66,858	50.00
51.00	05100	RECOVERY ROOM	61,576	4,204	24,090	0	8,723	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	18,939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,324	20,701	31,815	0	103,954	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	3,756	0	1,470	0	0	54.01
54.02	03480	ONCOLOGY	130,317	8,895	50,982	0	33,691	54.02
57.00	05700	CT SCAN	35,416	0	13,855	0	18,388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	67,345	0	26,346	0	106,489	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,781	0	7,348	0	35,558	65.00
66.00	06600	PHYSICAL THERAPY	45,719	7,642	17,886	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,683	0	1,050	0	7,352	69.00
69.01	06901	CARDIAC REHAB	43,358	0	16,962	0	22,269	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,040	0	9,405	0	26,174	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	129,753	6,194	50,761	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	66,943	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	151,701	0	59,347	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	4,347	0	1,700	0	0	90.00
90.01	09001	RHEUMATOLOGY	12,637	0	4,944	0	25,408	90.01
91.00	09100	EMERGENCY	155,779	67,382	60,943	0	148,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,795,347	263,739	662,445	617,426	863,360	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,798	0	5,007	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	265,920	12,990	104,033	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	41,791	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	18,594	0	7,274	0	0	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,092,659	276,729	778,759	617,426	905,151	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
			13.00	16.00	17.00	17.01	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	218,039					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	882,875				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	148,124		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,324	386,058	0	123,103	3,752,512	30.00
31.00	03100	INTENSIVE CARE UNIT	37,502	0	0	25,021	1,737,554	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	312,392	0	0	3,963,725	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	368,766	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	525,620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	2,241,827	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	166,626	54.01
54.02	03480	ONCOLOGY	0	0	0	0	4,650,488	54.02
57.00	05700	CT SCAN	0	0	0	0	641,779	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	3,124,042	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	732,407	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	858,691	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	116,601	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	59,508	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	228,533	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	531,020	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	42,163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,391,716	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0	0	2,692,788	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	0	2,078,856	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	0	2,138,887	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	11,024	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	368,904	90.01
91.00	09100	EMERGENCY	96,213	184,425	0	0	4,241,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	218,039	882,875	0	148,124	36,665,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	32,460	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	6,411,238	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	535,683	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	47,159	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
		13.00	16.00	17.00	17.01	24.00	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	218,039	882,875	0	148,124	43,692,511	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
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
17.01	01701	UTILIZATION REVIEW				17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,752,512		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,737,554		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,963,725		50.00
51.00	05100	RECOVERY ROOM	0	368,766		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	525,620		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,241,827		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	166,626		54.01
54.02	03480	ONCOLOGY	0	4,650,488		54.02
57.00	05700	CT SCAN	0	641,779		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	3,124,042		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	732,407		65.00
66.00	06600	PHYSICAL THERAPY	0	858,691		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	116,601		67.00
68.00	06800	SPEECH PATHOLOGY	0	59,508		68.00
69.00	06900	ELECTROCARDIOLOGY	0	228,533		69.00
69.01	06901	CARDIAC REHAB	0	531,020		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	42,163		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,391,716		73.00
73.01	03950	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	2,692,788		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	2,078,856		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	2,138,887		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	11,024		90.00
90.01	09001	RHEUMATOLOGY	0	368,904		90.01
91.00	09100	EMERGENCY	0	4,241,934		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	36,665,971		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,460		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,411,238		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	535,683		192.01
192.02	19203	RHEUMATOLOGY	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	DME	0	0		193.01
193.02	19302	LACTATION CONSULTING	0	0		193.02
193.03	19303	DIABETIC COUNSELING	0	0		193.03
194.00	07950	VACANT SPACE	0	0		194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.01	07951	BOARD OF HEALTH	0	47,159		194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	43,692,511		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,942	3,942	3,942		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	366,429	366,429	472	366,901	5.00
7.00	00700	OPERATION OF PLANT	0	266,537	266,537	58	17,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	17,417	17,417	5	2,171	8.00
9.00	00900	HOUSEKEEPING	0	16,283	16,283	76	6,384	9.00
10.00	01000	DIETARY	0	90,100	90,100	20	4,079	10.00
11.00	01100	CAFETERIA	0	41,327	41,327	47	7,098	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,134	17,134	14	1,594	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	101,823	101,823	46	5,809	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	8,580	8,580	14	1,087	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	153,043	153,043	340	18,758	30.00
31.00	03100	INTENSIVE CARE UNIT	0	73,198	73,198	116	11,423	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	210,782	210,782	123	27,204	50.00
51.00	05100	RECOVERY ROOM	0	59,130	59,130	19	2,269	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	149	4,255	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	78,093	78,093	175	16,828	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,607	3,607	0	1,355	54.01
54.02	03480	ONCOLOGY	0	125,140	125,140	58	37,170	54.02
57.00	05700	CT SCAN	0	34,010	34,010	31	4,821	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	64,670	64,670	135	24,552	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	18,035	18,035	68	5,632	65.00
66.00	06600	PHYSICAL THERAPY	0	43,903	43,903	0	6,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	979	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	500	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,576	2,576	13	1,826	69.00
69.01	06901	CARDIAC REHAB	0	41,636	41,636	47	3,765	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,085	23,085	49	11,186	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	124,599	124,599	242	21,043	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	64,283	64,283	198	16,894	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	145,674	145,674	175	16,188	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	4,174	4,174	0	42	90.00
90.01	09001	RHEUMATOLOGY	0	12,135	12,135	67	2,737	90.01
91.00	09100	EMERGENCY	0	149,591	149,591	550	29,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,360,936	2,360,936	3,307	311,818	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,290	12,290	0	123	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	255,355	255,355	582	50,634	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	53	4,147	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	17,855	17,855	0	179	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,646,436	2,646,436	3,942	366,901	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	284,167					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,463	22,056				8.00
9.00	00900	HOUSEKEEPING	2,303	124	25,170			9.00
10.00	01000	DIETARY	12,741	91	1,186	108,217		10.00
11.00	01100	CAFETERIA	5,844	0	544	0	54,860	11.00
13.00	01300	NURSING ADMINISTRATION	2,423	0	226	0	208	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,399	0	1,341	0	2,639	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	1,213	0	113	0	379	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,642	4,798	2,015	89,937	7,883	30.00
31.00	03100	INTENSIVE CARE UNIT	10,351	3,705	964	18,280	3,506	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,807	3,135	2,775	0	4,052	50.00
51.00	05100	RECOVERY ROOM	8,362	335	779	0	529	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,148	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,043	1,650	1,028	0	6,301	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	510	0	47	0	0	54.01
54.02	03480	ONCOLOGY	17,696	709	1,648	0	2,042	54.02
57.00	05700	CT SCAN	4,809	0	448	0	1,114	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	9,145	0	852	0	6,454	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,550	0	237	0	2,155	65.00
66.00	06600	PHYSICAL THERAPY	6,208	609	578	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	364	0	34	0	446	69.00
69.01	06901	CARDIAC REHAB	5,888	0	548	0	1,350	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,264	0	304	0	1,586	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	17,619	494	1,641	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	9,090	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	20,600	0	1,918	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	590	0	55	0	0	90.00
90.01	09001	RHEUMATOLOGY	1,716	0	160	0	1,540	90.01
91.00	09100	EMERGENCY	21,154	5,371	1,970	0	8,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	243,794	21,021	21,411	108,217	52,327	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,738	0	162	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,110	1,035	3,362	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	2,533	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	2,525	0	235	0	0	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	284,167	22,056	25,170	108,217	54,860	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
			13.00	16.00	17.00	17.01	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	21,599					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	126,057				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	11,386		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,353	55,122	0	9,463	371,354	30.00
31.00	03100	INTENSIVE CARE UNIT	3,715	0	0	1,923	127,181	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,603	0	0	322,481	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	71,423	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	5,552	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	115,118	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	5,519	54.01
54.02	03480	ONCOLOGY	0	0	0	0	184,463	54.02
57.00	05700	CT SCAN	0	0	0	0	45,233	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	105,808	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	28,677	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	57,910	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	979	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	500	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	5,259	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	53,234	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	39,474	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0	0	165,638	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	0	90,465	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	0	184,555	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	4,861	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	18,355	90.01
91.00	09100	EMERGENCY	9,531	26,332	0	0	253,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,599	126,057	0	11,386	2,257,518	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,313	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	347,078	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	6,733	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	20,794	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
		13.00	16.00	17.00	17.01	24.00	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	21,599	126,057	0	11,386	2,646,436	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
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
17.01	01701	UTILIZATION REVIEW				17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	371,354		30.00
31.00	03100	INTENSIVE CARE UNIT	0	127,181		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	322,481		50.00
51.00	05100	RECOVERY ROOM	0	71,423		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	5,552		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	115,118		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	5,519		54.01
54.02	03480	ONCOLOGY	0	184,463		54.02
57.00	05700	CT SCAN	0	45,233		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	105,808		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	28,677		65.00
66.00	06600	PHYSICAL THERAPY	0	57,910		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	979		67.00
68.00	06800	SPEECH PATHOLOGY	0	500		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,259		69.00
69.01	06901	CARDIAC REHAB	0	53,234		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	354		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,474		73.00
73.01	03950	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	165,638		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	90,465		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	184,555		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	4,861		90.00
90.01	09001	RHEUMATOLOGY	0	18,355		90.01
91.00	09100	EMERGENCY	0	253,125		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,257,518		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,313		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	347,078		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	6,733		192.01
192.02	19203	RHEUMATOLOGY	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	DME	0	0		193.01
193.02	19302	LACTATION CONSULTING	0	0		193.02
193.03	19303	DIABETIC COUNSELING	0	0		193.03
194.00	07950	VACANT SPACE	0	0		194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.01	07951	BOARD OF HEALTH	0	20,794		194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,646,436		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	102,715					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	153	22,016,448				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,222	2,636,404	-7,051,762	36,640,749		5.00
7.00	00700	OPERATION OF PLANT	10,345	322,811	0	1,754,914	77,995	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	676	28,534	0	216,856	676	8.00
9.00	00900	HOUSEKEEPING	632	424,432	0	637,548	632	9.00
10.00	01000	DIETARY	3,497	113,906	0	407,349	3,497	10.00
11.00	01100	CAFETERIA	1,604	264,078	0	708,855	1,604	11.00
13.00	01300	NURSING ADMINISTRATION	665	77,109	0	159,152	665	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,952	257,071	0	580,155	3,952	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	333	75,456	0	108,544	333	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,940	1,899,350	0	1,873,363	5,940	30.00
31.00	03100	INTENSIVE CARE UNIT	2,841	647,255	0	1,140,804	2,841	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,181	688,556	0	2,716,883	8,181	50.00
51.00	05100	RECOVERY ROOM	2,295	106,543	0	226,568	2,295	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	832,046	0	424,905	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,031	975,699	0	1,680,591	3,031	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	140	0	0	135,351	140	54.01
54.02	03480	ONCOLOGY	4,857	323,400	0	3,712,170	4,857	54.02
57.00	05700	CT SCAN	1,320	174,884	0	481,460	1,320	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,510	754,007	0	2,451,964	2,510	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	700	378,253	0	562,469	700	65.00
66.00	06600	PHYSICAL THERAPY	1,704	0	0	660,354	1,704	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	97,782	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	49,904	0	68.00
69.00	06900	ELECTROCARDIOLOGY	100	71,908	0	182,353	100	69.00
69.01	06901	CARDIAC REHAB	1,616	260,295	0	376,056	1,616	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	35,358	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	896	272,539	0	1,117,103	896	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	4,836	1,350,853	0	2,101,610	4,836	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	2,495	1,108,584	0	1,687,200	2,495	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	5,654	980,247	0	1,616,695	5,654	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	162	0	0	4,174	162	90.00
90.01	09001	RHEUMATOLOGY	471	373,634	0	273,314	471	90.01
91.00	09100	EMERGENCY	5,806	3,071,549	0	2,959,259	5,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,634	18,469,403	-7,051,762	31,141,063	66,914	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	0	0	12,290	477	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,911	3,248,382	0	5,055,361	9,911	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	298,663	0	414,180	0	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	693	0	0	17,855	693	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
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)	2,646,436	5,198,469		7,051,762	2,092,659	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.764844	0.236118		0.192457	26.830681	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		3,942		366,901	284,167	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000179		0.010013	3.643400	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: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	178,565					8.00
9.00	00900	HOUSEKEEPING	1,002	74,192				9.00
10.00	01000	DIETARY	740	3,497	2,297			10.00
11.00	01100	CAFETERIA	0	1,604	0	302,488		11.00
13.00	01300	NURSING ADMINISTRATION	0	665	0	1,148	112,391	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,952	0	14,553	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	333	0	2,092	0	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,845	5,940	1,909	43,466	43,466	30.00
31.00	03100	INTENSIVE CARE UNIT	29,996	2,841	388	19,331	19,331	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,382	8,181	0	22,343	0	50.00
51.00	05100	RECOVERY ROOM	2,713	2,295	0	2,915	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,329	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,358	3,031	0	34,740	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	140	0	0	0	54.01
54.02	03480	ONCOLOGY	5,740	4,857	0	11,259	0	54.02
57.00	05700	CT SCAN	0	1,320	0	6,145	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,510	0	35,587	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	700	0	11,883	0	65.00
66.00	06600	PHYSICAL THERAPY	4,931	1,704	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	100	0	2,457	0	69.00
69.01	06901	CARDIAC REHAB	0	1,616	0	7,442	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	896	0	8,747	0	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	3,997	4,836	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	5,654	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	162	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	471	0	8,491	0	90.01
91.00	09100	EMERGENCY	43,479	5,806	0	49,594	49,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,183	63,111	2,297	288,522	112,391	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	477	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,382	9,911	0	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	13,966	0	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
194.01	07951	BOARD OF HEALTH	0	693	0	0	0	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
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)	276,729	778,759	617,426	905,151	218,039	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.549738	10.496536	268.796691	2.992353	1.940004	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,056	25,170	108,217	54,860	21,599	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.123518	0.339255	47.112320	0.181363	0.192177	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: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)		
			16.00	17.00	17.01		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
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	129,196				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	2,297		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	56,494	0	1,909		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	388		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	45,714	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.01
54.02	03480	ONCOLOGY	0	0	0		54.02
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
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
73.01	03950	ONCOLOGY	0	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	RHEUMATOLOGY	0	0	0		90.01
91.00	09100	EMERGENCY	26,988	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,196	0	2,297		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	JOHNSON/NICHOLS WIC	0	0	0		192.01
192.02	19203	RHEUMATOLOGY	0	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	DME	0	0	0		193.01
193.02	19302	LACTATION CONSULTING	0	0	0		193.02
193.03	19303	DIABETIC COUNSELING	0	0	0		193.03
194.00	07950	VACANT SPACE	0	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	0	0		194.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 8/28/2020 10:03 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)		
			16.00	17.00	17.01		
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0		194.02
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)	882,875	0	148,124		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.833609	0.000000	64.485851		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	126,057	0	11,386		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.975704	0.000000	4.956900		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: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,752,512		3,752,512	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,737,554		1,737,554	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,963,725		3,963,725	0	0	50.00
51.00	05100	RECOVERY ROOM	368,766		368,766	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	525,620		525,620	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,241,827		2,241,827	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	166,626		166,626	0	0	54.01
54.02	03480	ONCOLOGY	4,650,488		4,650,488	0	0	54.02
57.00	05700	CT SCAN	641,779		641,779	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,124,042		3,124,042	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	732,407	0	732,407	0	0	65.00
66.00	06600	PHYSICAL THERAPY	858,691	0	858,691	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,601	0	116,601	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	59,508	0	59,508	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	228,533		228,533	0	0	69.00
69.01	06901	CARDIAC REHAB	531,020		531,020	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	42,163		42,163	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,391,716		1,391,716	0	0	73.00
73.01	03950	ONCOLOGY	0		0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	2,692,788		2,692,788	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	2,078,856		2,078,856	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	2,138,887		2,138,887	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	11,024		11,024	0	0	90.00
90.01	09001	RHEUMATOLOGY	368,904		368,904	0	0	90.01
91.00	09100	EMERGENCY	4,241,934		4,241,934	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,378,344		1,378,344		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	38,044,315	0	38,044,315	0	0	200.00
201.00		Less Observation Beds	1,378,344		1,378,344		0	201.00
202.00		Total (see instructions)	36,665,971	0	36,665,971	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,633,038		4,633,038			30.00
31.00	03100	INTENSIVE CARE UNIT	1,724,323		1,724,323			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	995,598	5,564,752	6,560,350	0.604194	0.000000	50.00
51.00	05100	RECOVERY ROOM	114,554	600,345	714,899	0.515830	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	42,249	464,032	506,281	1.038198	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	894,126	8,701,872	9,595,998	0.233621	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	35,201	1,411,202	1,446,403	0.115200	0.000000	54.01
54.02	03480	ONCOLOGY	6,796	8,085,736	8,092,532	0.574664	0.000000	54.02
57.00	05700	CT SCAN	630,157	19,637,472	20,267,629	0.031665	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,530,879	15,555,929	17,086,808	0.182834	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,597,344	1,066,923	2,664,267	0.274900	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	524,592	2,394,895	2,919,487	0.294124	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,192	397,041	541,233	0.215436	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	66,590	180,371	246,961	0.240961	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	39,634	1,294,223	1,333,857	0.171332	0.000000	69.00
69.01	06901	CARDIAC REHAB	2,742	685,988	688,730	0.771013	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	25,847	103,233	129,080	0.326642	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	976,073	2,625,623	3,601,696	0.386406	0.000000	73.00
73.01	03950	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	2,149,509	2,149,509			88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	2,067,206	2,067,206			88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	1,376,133	1,376,133			88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	4,622	4,622	2.385115	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	10,774	10,774	34.240208	0.000000	90.01
91.00	09100	EMERGENCY	342,072	19,485,706	19,827,778	0.213939	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,161,171	2,161,171	0.637776	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	14,326,007	96,024,758	110,350,765			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,326,007	96,024,758	110,350,765			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.01
54.02	03480	ONCOLOGY	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
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
73.01	03950	ONCOLOGY	0.000000		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED			88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE			88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE			88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	RHEUMATOLOGY	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 10:03 am

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	3,752,512		3,752,512	0	3,752,512	30.00
31.00	03100	INTENSIVE CARE UNIT	1,737,554		1,737,554	0	1,737,554	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,963,725		3,963,725	0	3,963,725	50.00
51.00	05100	RECOVERY ROOM	368,766		368,766	0	368,766	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	525,620		525,620	0	525,620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,241,827		2,241,827	0	2,241,827	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	166,626		166,626	0	166,626	54.01
54.02	03480	ONCOLOGY	4,650,488		4,650,488	0	4,650,488	54.02
57.00	05700	CT SCAN	641,779		641,779	0	641,779	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,124,042		3,124,042	0	3,124,042	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	732,407	0	732,407	0	732,407	65.00
66.00	06600	PHYSICAL THERAPY	858,691	0	858,691	0	858,691	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,601	0	116,601	0	116,601	67.00
68.00	06800	SPEECH PATHOLOGY	59,508	0	59,508	0	59,508	68.00
69.00	06900	ELECTROCARDIOLOGY	228,533		228,533	0	228,533	69.00
69.01	06901	CARDIAC REHAB	531,020		531,020	0	531,020	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	42,163		42,163	0	42,163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,391,716		1,391,716	0	1,391,716	73.00
73.01	03950	ONCOLOGY	0		0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	2,692,788		2,692,788	0	2,692,788	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	2,078,856		2,078,856	0	2,078,856	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	2,138,887		2,138,887	0	2,138,887	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	11,024		11,024	0	11,024	90.00
90.01	09001	RHEUMATOLOGY	368,904		368,904	0	368,904	90.01
91.00	09100	EMERGENCY	4,241,934		4,241,934	0	4,241,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,378,344		1,378,344		1,378,344	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	38,044,315	0	38,044,315	0	38,044,315	200.00
201.00		Less Observation Beds	1,378,344		1,378,344		1,378,344	201.00
202.00		Total (see instructions)	36,665,971	0	36,665,971	0	36,665,971	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 10:03 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,633,038		4,633,038			30.00
31.00	03100	INTENSIVE CARE UNIT	1,724,323		1,724,323			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	995,598	5,564,752	6,560,350	0.604194	0.000000	50.00
51.00	05100	RECOVERY ROOM	114,554	600,345	714,899	0.515830	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	42,249	464,032	506,281	1.038198	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	894,126	8,701,872	9,595,998	0.233621	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	35,201	1,411,202	1,446,403	0.115200	0.000000	54.01
54.02	03480	ONCOLOGY	6,796	8,085,736	8,092,532	0.574664	0.000000	54.02
57.00	05700	CT SCAN	630,157	19,637,472	20,267,629	0.031665	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,530,879	15,555,929	17,086,808	0.182834	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,597,344	1,066,923	2,664,267	0.274900	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	524,592	2,394,895	2,919,487	0.294124	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,192	397,041	541,233	0.215436	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	66,590	180,371	246,961	0.240961	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	39,634	1,294,223	1,333,857	0.171332	0.000000	69.00
69.01	06901	CARDIAC REHAB	2,742	685,988	688,730	0.771013	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	25,847	103,233	129,080	0.326642	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	976,073	2,625,623	3,601,696	0.386406	0.000000	73.00
73.01	03950	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	2,149,509	2,149,509	1.252746	0.000000	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	2,067,206	2,067,206	1.005636	0.000000	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	1,376,133	1,376,133	1.554273	0.000000	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	4,622	4,622	2.385115	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	10,774	10,774	34.240208	0.000000	90.01
91.00	09100	EMERGENCY	342,072	19,485,706	19,827,778	0.213939	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,161,171	2,161,171	0.637776	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	14,326,007	96,024,758	110,350,765			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,326,007	96,024,758	110,350,765			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 8/28/2020 10:03 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.01
54.02	03480	ONCOLOGY	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
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
73.01	03950	ONCOLOGY	0.000000		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	RHEUMATOLOGY	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	322,481	6,560,350	0.049156	481,959	23,691	50.00
51.00	05100	RECOVERY ROOM	71,423	714,899	0.099906	50,043	5,000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,552	506,281	0.010966	22,617	248	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,118	9,595,998	0.011996	415,140	4,980	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	5,519	1,446,403	0.003816	19,012	73	54.01
54.02	03480	ONCOLOGY	184,463	8,092,532	0.022794	756	17	54.02
57.00	05700	CT SCAN	45,233	20,267,629	0.002232	324,146	723	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	105,808	17,086,808	0.006192	765,608	4,741	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	28,677	2,664,267	0.010764	781,576	8,413	65.00
66.00	06600	PHYSICAL THERAPY	57,910	2,919,487	0.019836	218,099	4,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	979	541,233	0.001809	54,038	98	67.00
68.00	06800	SPEECH PATHOLOGY	500	246,961	0.002025	36,706	74	68.00
69.00	06900	ELECTROCARDIOLOGY	5,259	1,333,857	0.003943	28,750	113	69.00
69.01	06901	CARDIAC REHAB	53,234	688,730	0.077293	1,954	151	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	354	129,080	0.002742	21,350	59	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,474	3,601,696	0.010960	354,533	3,886	73.00
73.01	03950	ONCOLOGY	0	0	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	165,638	2,149,509	0.077059	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	90,465	2,067,206	0.043762	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	184,555	1,376,133	0.134111	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	4,861	4,622	1.051709	0	0	90.00
90.01	09001	RHEUMATOLOGY	18,355	10,774	1.703638	0	0	90.01
91.00	09100	EMERGENCY	253,125	19,827,778	0.012766	14,575	186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	136,402	2,161,171	0.063115	0	0	92.00
200.00		Total (lines 50 through 199)	1,895,385	103,993,404		3,590,862	56,779	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
54.02	03480	ONCOLOGY	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,560,350	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	714,899	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	506,281	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,595,998	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	1,446,403	0.000000	54.01
54.02	03480	ONCOLOGY	0	0	0	8,092,532	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	20,267,629	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	17,086,808	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,664,267	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,919,487	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	541,233	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	246,961	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,333,857	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	688,730	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	129,080	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,601,696	0.000000	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0	2,149,509	0.000000	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	2,067,206	0.000000	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	1,376,133	0.000000	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	4,622	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	10,774	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	19,827,778	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,161,171	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	103,993,404		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	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	481,959	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	50,043	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	22,617	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	415,140	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	19,012	0	0	0	54.01
54.02	03480	ONCOLOGY	0.000000	756	0	0	0	54.02
57.00	05700	CT SCAN	0.000000	324,146	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	765,608	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	781,576	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	218,099	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	54,038	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	36,706	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	28,750	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	1,954	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	21,350	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	354,533	0	0	0	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000	0	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	14,575	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,590,862	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.604194	0	1,724,875	0	0	50.00
51.00	05100	RECOVERY ROOM	0.515830	0	142,408	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.038198	0	110,092	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233621	0	2,405,101	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.115200	0	504,007	0	0	54.01
54.02	03480	ONCOLOGY	0.574664	0	4,070,309	1,193	0	54.02
57.00	05700	CT SCAN	0.031665	0	5,462,585	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.182834	0	5,283,012	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.274900	0	317,637	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.294124	0	699,052	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.215436	0	140,572	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.240961	0	28,127	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171332	0	328,474	0	0	69.00
69.01	06901	CARDIAC REHAB	0.771013	0	225,488	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.326642	0	53,958	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.386406	0	451,726	0	0	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000				0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000				0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000				0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.385115	0	738	0	0	90.00
90.01	09001	RHEUMATOLOGY	34.240208	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.213939	0	3,935,008	542	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.637776	0	815,446	0	0	92.00
200.00		Subtotal (see instructions)		0	26,698,615	1,735	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	26,698,615	1,735	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,042,159	0		50.00
51.00	05100	RECOVERY ROOM	73,458	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	114,297	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	561,882	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	58,062	0		54.01
54.02	03480	ONCOLOGY	2,339,060	686		54.02
57.00	05700	CT SCAN	172,973	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	965,914	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	87,318	0		65.00
66.00	06600	PHYSICAL THERAPY	205,608	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	30,284	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,778	0		68.00
69.00	06900	ELECTROCARDIOLOGY	56,278	0		69.00
69.01	06901	CARDIAC REHAB	173,854	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,625	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	174,550	0		73.00
73.01	03950	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	1,760	0		90.00
90.01	09001	RHEUMATOLOGY	0	0		90.01
91.00	09100	EMERGENCY	841,852	116		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	520,072	0		92.00
200.00		Subtotal (see instructions)	7,443,784	802		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,443,784	802		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.604194	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.515830	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.038198	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233621	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.115200	0	0	0	0	54.01
54.02	03480	ONCOLOGY	0.574664	0	0	0	0	54.02
57.00	05700	CT SCAN	0.031665	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.182834	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.274900	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.294124	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.215436	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.240961	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171332	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.771013	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.326642	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.386406	0	0	0	0	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000				0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000				0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000				0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.385115	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	34.240208	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.213939	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.637776	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.01
54.02	03480	ONCOLOGY	0	0	54.02
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	03950	ONCOLOGY	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,217	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)	1,909	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	335	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	69	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)	1,078	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)	309	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	137.42	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,752,512	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)	9,482	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)	362,498	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,390,014	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)	3,390,014	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)	1,053.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,135,975	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)	1,135,975	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,737,554	388	4,478.23	196	877,733	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,043,353	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,057,061	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)	325,618	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)	325,618	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,308	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,053.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,378,344	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	371,354	3,752,512	0.098961	1,378,344	136,402	90.00
91.00	Nursing School cost	0	3,752,512	0.000000	1,378,344	0	91.00
92.00	Allied health cost	0	3,752,512	0.000000	1,378,344	0	92.00
93.00	All other Medical Education	0	3,752,512	0.000000	1,378,344	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:03 am

Title XIX | 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)	3,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,217	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)	1,909	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	335	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	69	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)	49	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.42	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,752,512	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)	9,482	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)	362,498	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,390,014	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)	3,390,014	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)	1,053.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	51,635	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)	51,635	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:03 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,737,554	388	4,478.23	0	0	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)	61,634	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	113,269	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,308	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,053.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,378,344	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 8/28/2020 10:03 am

Title XIX | 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	371,354	3,752,512	0.098961	1,378,344	136,402	90.00
91.00	Nursing School cost	0	3,752,512	0.000000	1,378,344	0	91.00
92.00	Allied health cost	0	3,752,512	0.000000	1,378,344	0	92.00
93.00	All other Medical Education	0	3,752,512	0.000000	1,378,344	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/28/2020 10:03 am

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		1,797,891		30.00
31.00	03100	INTENSIVE CARE UNIT		811,764		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.604194	481,959	291,197	50.00
51.00	05100	RECOVERY ROOM	0.515830	50,043	25,814	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.038198	22,617	23,481	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233621	415,140	96,985	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.115200	19,012	2,190	54.01
54.02	03480	ONCOLOGY	0.574664	756	434	54.02
57.00	05700	CT SCAN	0.031665	324,146	10,264	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.182834	765,608	139,979	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.274900	781,576	214,855	65.00
66.00	06600	PHYSICAL THERAPY	0.294124	218,099	64,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.215436	54,038	11,642	67.00
68.00	06800	SPEECH PATHOLOGY	0.240961	36,706	8,845	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171332	28,750	4,926	69.00
69.01	06901	CARDIAC REHAB	0.771013	1,954	1,507	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.326642	21,350	6,974	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.386406	354,533	136,994	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000		0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000		0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000		0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.385115	0	0	90.00
90.01	09001	RHEUMATOLOGY	34.240208	0	0	90.01
91.00	09100	EMERGENCY	0.213939	14,575	3,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.637776	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,590,862	1,043,353	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,590,862		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.604194	33,411	20,187	50.00
51.00	05100	RECOVERY ROOM	0.515830	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.038198	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233621	15,157	3,541	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.115200	0	0	54.01
54.02	03480	ONCOLOGY	0.574664	0	0	54.02
57.00	05700	CT SCAN	0.031665	12,235	387	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.182834	52,303	9,563	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.274900	96,725	26,590	65.00
66.00	06600	PHYSICAL THERAPY	0.294124	100,176	29,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.215436	37,065	7,985	67.00
68.00	06800	SPEECH PATHOLOGY	0.240961	9,186	2,213	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171332	2,803	480	69.00
69.01	06901	CARDIAC REHAB	0.771013	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.326642	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.386406	21,144	8,170	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000		0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000		0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000		0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	2.385115	0	0	90.00
90.01	09001	RHEUMATOLOGY	34.240208	0	0	90.01
91.00	09100	EMERGENCY	0.213939	2,799	599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.637776	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		383,004	109,179	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)		383,004		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 8/28/2020 10:03 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		56,586		30.00
31.00	03100	INTENSIVE CARE UNIT		32,941		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.604194	39,763	24,025	50.00
51.00	05100	RECOVERY ROOM	0.515830	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.038198	1,271	1,320	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233621	9,412	2,199	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.115200	672	77	54.01
54.02	03480	ONCOLOGY	0.574664	6,040	3,471	54.02
57.00	05700	CT SCAN	0.031665	26,648	844	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.182834	45,209	8,266	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.274900	13,339	3,667	65.00
66.00	06600	PHYSICAL THERAPY	0.294124	5,924	1,742	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.215436	298	64	67.00
68.00	06800	SPEECH PATHOLOGY	0.240961	297	72	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171332	8,081	1,385	69.00
69.01	06901	CARDIAC REHAB	0.771013	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.326642	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.386406	26,557	10,262	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	1.252746	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	1.005636	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	1.554273	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	2.385115	0	0	90.00
90.01	09001	RHEUMATOLOGY	34.240208	0	0	90.01
91.00	09100	EMERGENCY	0.213939	19,820	4,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.637776	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		203,331	61,634	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)		203,331		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/28/2020 10:03 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,444,586	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,444,586	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,519,032	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)	49,545	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,312,292	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)	3,157,195	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)	3,157,195	30.00
31.00	Primary payer payments	5,599	31.00
32.00	Subtotal (line 30 minus line 31)	3,151,596	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)	860,503	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	559,327	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	763,078	36.00
37.00	Subtotal (see instructions)	3,710,923	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)		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)	3,710,923	40.00
40.01	Sequestration adjustment (see instructions)	74,218	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,200,480	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-563,775	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,029,802		4,200,480	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/14/2019	74,100		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)		74,100		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,103,902		4,200,480	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		418,590		563,775	6.02
7.00	Total Medicare program liability (see instructions)		2,685,312		3,636,705	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: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		464,998		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)		464,998		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		52,515		0	6.02
7.00	Total Medicare program liability (see instructions)		412,483		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: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/28/2020 10:03 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	328,874	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)	110,271	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	309	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)	439,145	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	439,145	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)	439,145	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	18,244	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	420,901	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)	420,901	0	19.00
19.01	Sequestration adjustment (see instructions)	8,418	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	464,998	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)	-52,515	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 8/28/2020 10:03 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,057,061	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,057,061	4.00
5.00	Primary payer payments	1,125	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,086,507	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,086,507	19.00
20.00	Deductibles (exclude professional component)	353,252	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,733,255	22.00
23.00	Coinsurance	6,479	23.00
24.00	Subtotal (line 22 minus line 23)	2,726,776	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	20,520	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	13,338	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,114	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,740,114	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,740,114	30.00
30.01	Sequestration adjustment (see instructions)	54,802	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,103,902	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-418,590	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 8/28/2020 10:03 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	113,269		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	113,269	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	113,269	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	89,527		8.00
9.00	Ancillary service charges	203,331	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	292,858	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	292,858	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	179,589	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	113,269	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	113,269	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	113,269	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	113,269	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	113,269	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	113,269	0	40.00
41.00	Interim payments	159,037	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-45,768	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 8/28/2020 10:03 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-2,188,860	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,924,197	0	0	0	4.00
5.00	Other receivable	4,455,370	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,446,957	0	0	0	6.00
7.00	Inventory	841,396	0	0	0	7.00
8.00	Prepaid expenses	491,234	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,076,380	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	195,501	0	0	0	12.00
13.00	Land improvements	356,155	0	0	0	13.00
14.00	Accumulated depreciation	-266,634	0	0	0	14.00
15.00	Buildings	34,682,383	0	0	0	15.00
16.00	Accumulated depreciation	-23,458,023	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,590,930	0	0	0	23.00
24.00	Accumulated depreciation	-20,626,578	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)	15,473,734	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,462,339	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	244,752	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,707,091	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,257,205	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,854,869	0	0	0	37.00
38.00	Salaries, wages, and fees payable	148,858	0	0	0	38.00
39.00	Payroll taxes payable	226,831	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,604,283	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	567,758	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,402,599	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,932,470	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)	12,932,470	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,335,069	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,922,136				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)	15,922,136	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,257,205	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 8/28/2020 10:03 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		20,358,938		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,436,802				2.00
3.00	Total (sum of line 1 and line 2)		15,922,136		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)		15,922,136		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)		15,922,136		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: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/28/2020 10:03 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,633,038		4,633,038	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,633,038		4,633,038	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,724,323		1,724,323	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)	1,724,323		1,724,323	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,357,361		6,357,361	17.00
18.00	Ancillary services	7,614,193	68,782,015	76,396,208	18.00
19.00	Outpatient services	342,072	21,651,499	21,993,571	19.00
20.00	PUTNAM PEDIATRICS AND INTERNAL MED	0	1,948,784	1,948,784	20.00
20.01	FAMILY MEDICINE OF CLOVERDALE	0	2,067,206	2,067,206	20.01
20.02	NORTH PUTNAM FAMILY HEALTHCARE	0	1,084,486	1,084,486	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	350,525	13,342,006	13,692,531	27.00
27.01	JOHNSON NICHOLS / WIC	0	425,224	425,224	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,664,151	109,301,220	123,965,371	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50,333,999		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)		50,333,999		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 8/28/2020 10:03 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	123,965,371	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,796,569	2.00
3.00	Net patient revenues (line 1 minus line 2)	43,168,802	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	50,333,999	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,165,197	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	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 & NON-OPERATING INC	2,728,395	24.00
25.00	Total other income (sum of lines 6-24)	2,728,395	25.00
26.00	Total (line 5 plus line 25)	-4,436,802	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,436,802	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 8/28/2020 10:03 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	533,226	0	533,226	0	533,226	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	289,911	0	289,911	0	289,911	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	175,293	0	175,293	0	175,293	5.00
6.00	Clinical Psychologist	118,854	0	118,854	0	118,854	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)	1,117,284	0	1,117,284	0	1,117,284	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	0	0	0	0	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	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,117,284	0	1,117,284	0	1,117,284	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	233,569	414,585	648,154	-98,162	549,992	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	233,569	414,585	648,154	-98,162	549,992	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,350,853	414,585	1,765,438	-98,162	1,667,276	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 8/28/2020 10:03 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	533,226		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	289,911		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	175,293		5.00
6.00	Clinical Psychologist	0	118,854		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	1,117,284		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,117,284		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-9,226	540,766		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-9,226	540,766		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-9,226	1,658,050		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 8/28/2020 10:03 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	279,900	0	279,900	0	279,900	1.00
2.00	Physician Assistant	447,869	0	447,869	0	447,869	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	133,571	0	133,571	0	133,571	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)	861,340	0	861,340	0	861,340	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	0	0	0	0	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	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	861,340	0	861,340	0	861,340	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	257,900	365,784	623,684	-123,029	500,655	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	257,900	365,784	623,684	-123,029	500,655	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,119,240	365,784	1,485,024	-123,029	1,361,995	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 8/28/2020 10:03 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	279,900		1.00
2.00	Physician Assistant	0	447,869		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	133,571		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	861,340		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	861,340		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-835	499,820		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-835	499,820		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-835	1,361,160		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 8/28/2020 10:03 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	321,900	0	321,900	0	321,900	1.00
2.00	Physician Assistant	50,486	0	50,486	0	50,486	2.00
3.00	Nurse Practitioner	198,799	0	198,799	0	198,799	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	82,130	0	82,130	0	82,130	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)	653,315	0	653,315	0	653,315	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	0	0	0	0	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	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	653,315	0	653,315	0	653,315	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	316,277	356,454	672,731	-77,765	594,966	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	316,277	356,454	672,731	-77,765	594,966	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	969,592	356,454	1,326,046	-77,765	1,248,281	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 8/28/2020 10:03 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	321,900		1.00
2.00	Physician Assistant	0	50,486		2.00
3.00	Nurse Practitioner	0	198,799		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	82,130		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	653,315		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	653,315		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-8,714	586,252		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-8,714	586,252		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,714	1,239,567		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 8/28/2020 10:03 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.57	5,013	4,200	6,594		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.38	3,376	2,100	4,998		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.95	8,389		11,592	11,592	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.93	889			889	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.88	9,278			12,481	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,117,284	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,117,284	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					540,766	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,034,738	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,575,504	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,575,504	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,575,504	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,692,788	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 8/28/2020 10:03 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.87	3,173	4,200	3,654		1.00
2.00	Physician Assistant	3.29	6,379	2,100	6,909		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.16	9,552		10,563	10,563	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.16	9,552			10,563	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					861,340	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					861,340	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					499,820	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					717,696	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,217,516	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,217,516	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,217,516	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,078,856	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 8/28/2020 10:03 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.91	3,872	4,200	8,022		1.00
2.00	Physician Assistant	0.58	1,095	2,100	1,218		2.00
3.00	Nurse Practitioner	1.56	1,698	2,100	3,276		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.05	6,665		12,516	12,516	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.05	6,665			12,516	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					653,315	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					653,315	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					586,252	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					899,320	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,485,572	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,485,572	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,485,572	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,138,887	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1333 Component CCN: 15-8515	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/28/2020 10:03 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,692,788	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			160,350	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,532,438	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,481	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			12,481	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			202.90	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)	0.00	84.70		8.00
9.00	Rate for Program covered visits (see instructions)	202.90	202.90		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,084		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	219,944		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	219,944		16.00
16.01	Total program charges (see instructions)(from contractor's records)		206,561		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.)		162,673		16.04
16.05	Total program cost (see instructions)	0	162,673		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,603		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		35,138		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		162,673		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,569		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		179,242		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)		179,242		26.00
26.01	Sequestration adjustment (see instructions)		3,585		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		143,215		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)		32,442		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: 15-1333 Component CCN: 15-8513	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/28/2020 10:03 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,078,856	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			118,390	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,960,466	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,563	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)			10,563	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			185.60	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)	0.00	84.70		8.00
9.00	Rate for Program covered visits (see instructions)	185.60	185.60		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,657		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	307,539		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	307,539		16.00
16.01	Total program charges (see instructions)(from contractor's records)		320,340		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.)		211,714		16.04
16.05	Total program cost (see instructions)	0	211,714		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,897		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		54,262		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		211,714		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		28,519		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		240,233		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)		240,233		26.00
26.01	Sequestration adjustment (see instructions)		4,805		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		163,769		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)		71,659		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: 15-1333 Component CCN: 15-8514	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/28/2020 10:03 am
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,138,887	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			97,065	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,041,822	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,516	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			12,516	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			163.14	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	84.70		8.00
9.00	Rate for Program covered visits (see instructions)	163.14	163.14		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,353		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	220,728		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	220,728		16.00
16.01	Total program charges (see instructions)(from contractor's records)		216,066		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.)		161,154		16.04
16.05	Total program cost (see instructions)	0	161,154		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,285		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		36,520		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		161,154		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,257		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		188,411		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)		188,411		26.00
26.01	Sequestration adjustment (see instructions)		3,768		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		181,862		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)		2,781		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: 15-1333 Component CCN: 15-8515	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 8/28/2020 10:03 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,117,284	1,117,284	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003742	0.013158	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,181	14,701	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	33,424	14,226	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	37,605	28,927	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,117,284	1,117,284	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,575,504	1,575,504	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.033658	0.025890	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	53,028	40,790	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	90,633	69,717	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	180	633	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	503.52	110.14	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	13	91	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	6,546	10,023	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)		160,350	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)		16,569	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-4 | Date/Time Prepared: 8/28/2020 10:03 am

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	861,340	861,340	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001926	0.009376	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,659	8,076	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	21,487	17,831	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	23,146	25,907	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	861,340	861,340	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,217,516	1,217,516	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.026872	0.030078	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	32,717	36,620	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	55,863	62,527	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	129	628	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	433.05	99.57	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	27	169	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	11,692	16,827	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)		118,390	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)		28,519	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1333 Component CCN: 15-8514	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 8/28/2020 10:03 am
	Title XVIII	RHC III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	653,315	653,315	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001637	0.009101	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,069	5,946	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	12,371	10,262	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	13,440	16,208	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	653,315	653,315	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,485,572	1,485,572	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.020572	0.024809	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	30,561	36,856	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	44,001	53,064	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	82	456	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	536.60	116.37	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	20	142	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	10,732	16,525	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)		97,065	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)		27,257	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-5 | Date/Time Prepared: 8/28/2020 10:03 am

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		143,215	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)		143,215	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		32,442	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		175,657	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: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-5 | Date/Time Prepared: 8/28/2020 10:03 am

RHC II | Cost

		Part B	
		mm/dd/yyyy	Amount
		1.00	2.00
1.00	Total interim payments paid to hospital-based RHC/FQHC		163,769
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
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)		
	Program to Provider		
3.01			0
3.02			0
3.03			0
3.04			0
3.05			0
	Provider to Program		
3.50			0
3.51			0
3.52			0
3.53			0
3.54			0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		163,769
	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)		
	Program to Provider		
5.01			0
5.02			0
5.03			0
	Provider to Program		
5.50			0
5.51			0
5.52			0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)		
6.01	SETTLEMENT TO PROVIDER		71,659
6.02	SETTLEMENT TO PROGRAM		0
7.00	Total Medicare program liability (see instructions)		235,428

			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: 15-1333 Component CCN: 15-8514	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/28/2020 10:03 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		181,862	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)		181,862	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		2,781	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		184,643	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00