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: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/21/2021 9:44 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 4/21/2021 Time: 9:44 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 CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[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) CARLOS ALCAZAR
Officer or Administrator of Provider(s)

VICE PRESIDENT AND 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	399,149	-680,820	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	151,508	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC - FPC I	0		34,848		0	10.00
10.01	RURAL HEALTH CLINIC - URGENT CARE II	0		12,666		0	10.01
10.02	RURAL HEALTH CLINIC - OB/GYN III	0		8,502		0	10.02
200.00	Total	0	550,657	-624,804	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 4/21/2021 9:44 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 416 E MAUMEE STREET	PO Box:			1.00
2.00	City: ANGOLA	State: IN	Zip Code: 47803-	County: STEUBEN	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	CAMERON MEMORIAL COMMUNITY HOSPITAL	151315	99915	1	02/01/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	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	CAMERON HOSPICE	151561	99915		05/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	CAMERON URGENT CARE	158545	99915		11/26/2019	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	CAMERON OB/GYN	158546	99915		11/25/2019	N	O	O	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2019	09/30/2020	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 4/21/2021 9:44 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	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: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/21/2021 9:44 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		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

		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)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/21/2021 9:44 am

		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.	N	N	N	N	109.00

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

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	277,216	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

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

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

		Part A	Part B	Title V	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

		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)	N	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: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/21/2021 9:44 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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part II Date/Time Prepared: 4/21/2021 9:44 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)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/22/2020	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/18/2020	Y	12/18/2020	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/21/2021 9:44 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.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	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.	Y	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.	Y	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.	JODI	SANDERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7956	JSANDERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/21/2021 9:44 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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I Date/Time Prepared: 4/21/2021 9:44 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	23	8,418	66,576.00	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)		23	8,418	66,576.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	732	3,672.00	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	9,150	70,248.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - FPC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC - URGENT CARE	88.01				0	26.01
26.02	RURAL HEALTH CLINIC - OB/GYN	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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I Date/Time Prepared: 4/21/2021 9:44 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)	835	70	2,774			1.00
2.00	HMO and other (see instructions)	630	255				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	371	0	371			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	358			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,206	70	3,503			7.00
8.00	INTENSIVE CARE UNIT	43	8	153			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		52	448			13.00
14.00	Total (see instructions)	1,249	130	4,104	0.00	388.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - FPC	1,421	2,027	8,616	0.00	11.05	26.00
26.01	RURAL HEALTH CLINIC - URGENT CARE	384	2,655	13,530	0.00	14.32	26.01
26.02	RURAL HEALTH CLINIC - OB/GYN	63	1,197	3,294	0.00	5.38	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	419.48	27.00
28.00	Observation Bed Days		25	1,239			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	1	19			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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I Date/Time Prepared: 4/21/2021 9:44 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	263	21	1,027	1.00
2.00	HMO and other (see instructions)			173	125		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	263	21	1,027	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - FPC	0.00					26.00
26.01	RURAL HEALTH CLINIC - URGENT CARE	0.00					26.01
26.02	RURAL HEALTH CLINIC - OB/GYN	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: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8 | Date/Time Prepared: 4/21/2021 9:44 am

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	1500 W MAUMEE STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLOA	IN	46703	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?	Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

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

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

		County	
		4.00	
2.00	City, State, ZIP Code, County	STEUBEN	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: 15-1315 Component CCN: 15-8530	Period: From 10/01/2019 To 09/30/2020	Worksheet S-8 Date/Time Prepared: 4/21/2021 9:44 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	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8 | Date/Time Prepared: 4/21/2021 9:44 am

RHC II | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	1381 N. WAYNE STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA	IN	46703	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	09:00	17:30	08:00	19:30	08:00	11.00

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:30	08:00	19:30	08:00	19:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1315 Component CCN: 15-8545	Period: From 10/01/2019 To 09/30/2020	Worksheet S-8 Date/Time Prepared: 4/21/2021 9:44 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	19:30	09:00	17:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8 | Date/Time Prepared: 4/21/2021 9:44 am

RHC III | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	306 E. MAUMEE STREET, SUITE 101	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA	IN	46703	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 from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

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

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

		Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8 | Date/Time Prepared: 4/21/2021 9:44 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	12:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-10 | Date/Time Prepared: 4/21/2021 9:44 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)	0.369585	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,901,463	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,864,463	6.00
7.00	Medicaid cost (line 1 times line 6)	5,863,268	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)	2,961,805	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)	2,961,805	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)	123,714	65,251	188,965	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	45,723	65,251	110,974	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)	45,723	65,251	110,974	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,967,887	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	560,646	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	862,532	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,105,355	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,819,164	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,930,138	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,891,943	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 4/21/2021 9:44 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	CAP REL COSTS-BLDG & FIXT		5,508,545	5,508,545	-160,232	5,348,313	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,236,214	2,236,214	1,807,744	4,043,958	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	71,089	8,176,069	8,247,158	0	8,247,158	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,278,155	7,610,387	11,888,542	-117,741	11,770,801	5.00
7.00	00700	OPERATION OF PLANT	918,541	2,341,444	3,259,985	0	3,259,985	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,675	40,675	0	40,675	8.00
9.00	00900	HOUSEKEEPING	766,434	467,557	1,233,991	0	1,233,991	9.00
10.00	01000	DIETARY	529,124	390,020	919,144	-656,905	262,239	10.00
11.00	01100	CAFETERIA	0	0	0	642,430	642,430	11.00
13.00	01300	NURSING ADMINISTRATION	794,268	576,061	1,370,329	0	1,370,329	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	200,780	127,032	327,812	0	327,812	14.00
15.00	01500	PHARMACY	525,496	3,542,314	4,067,810	-2,441,309	1,626,501	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	506,595	102,752	609,347	0	609,347	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,217,204	1,278,218	3,495,422	617,809	4,113,231	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	116,548	116,548	31.00
43.00	04300	NURSERY	0	0	0	57,704	57,704	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,506,192	1,194,935	2,701,127	-703,296	1,997,831	50.00
51.00	05100	RECOVERY ROOM	0	0	0	703,296	703,296	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,114,020	100,525	1,214,545	-795,206	419,339	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,732,290	895,945	2,628,235	0	2,628,235	54.00
60.00	06000	LABORATORY	1,059,314	1,934,853	2,994,167	0	2,994,167	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	938,992	322,334	1,261,326	-335,751	925,575	65.00
65.01	06501	SLEEP LAB	0	0	0	65,923	65,923	65.01
66.00	06600	PHYSICAL THERAPY	958,116	21,616	979,732	0	979,732	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,431	5,431	269,828	275,259	69.00
69.01	06901	CARDIAC REHAB	58,178	7,494	65,672	0	65,672	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,650,929	2,650,929	-1,276,176	1,374,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,276,176	1,276,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	1,667,892	1,667,892	0	1,667,892	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	1,036,038	77,897	1,113,935	0	1,113,935	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	1,398,793	186,457	1,585,250	-242,552	1,342,698	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	1,164,283	67,757	1,232,040	-185,143	1,046,897	88.02
90.00	09000	CLINIC	137,264	24,144	161,408	0	161,408	90.00
90.01	09001	CLINIC- ORTHO	407,837	1,113,826	1,521,663	0	1,521,663	90.01
90.02	09002	CLINIC - PEDS & ENT	1,167,082	29,538	1,196,620	395,198	1,591,818	90.02
90.03	09003	IV THERAPY	136,606	13,250	149,856	2,360,744	2,510,600	90.03
90.04	09004	OP PSYCH	558,254	12,197	570,451	0	570,451	90.04
91.00	09100	EMERGENCY	1,840,240	221,794	2,062,034	3,145	2,065,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,558,311	1,558,311	-1,558,311	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	0	48	48	0	48	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,021,185	44,504,461	70,525,646	-156,077	70,369,569	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	59,534	10,497	70,031	0	70,031	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	2,427	2,427	0	2,427	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	2,452	23,931	26,383	0	26,383	194.04
194.05	07955	MARKETING	348,803	666,018	1,014,821	21,521	1,036,342	194.05
194.06	07956	GUEST MEALS	0	0	0	14,475	14,475	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	242,552	242,552	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	185,143	185,143	194.11
194.12	07962	TRINE STUDENT HEALTH	88,029	1,954	89,983	0	89,983	194.12
194.13	07963	OCCUPATIONAL HEALTH	240,924	82,836	323,760	0	323,760	194.13
194.14	07964	IMMUNIZATION CLINIC	19,290	981	20,271	80,565	100,836	194.14
194.15	07965	FOUNDATION	126,852	267,272	394,124	7,019	401,143	194.15

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 4/21/2021 9:44 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	
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	699,217	16,834	716,051	-395,198	320,853	194.17
200.00		TOTAL (SUM OF LINES 118 through 199)	27,606,286	45,577,211	73,183,497	0	73,183,497	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,561,004	3,787,309	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-174,442	3,869,516	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-195,366	8,051,792	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,333,317	9,437,484	5.00
7.00	00700	OPERATION OF PLANT	-3,300	3,256,685	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,675	8.00
9.00	00900	HOUSEKEEPING	0	1,233,991	9.00
10.00	01000	DIETARY	-9,142	253,097	10.00
11.00	01100	CAFETERIA	-191,490	450,940	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,370,329	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	327,812	14.00
15.00	01500	PHARMACY	-8,330	1,618,171	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-515	608,832	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-537,899	3,575,332	30.00
31.00	03100	INTENSIVE CARE UNIT	0	116,548	31.00
43.00	04300	NURSERY	0	57,704	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-541,739	1,456,092	50.00
51.00	05100	RECOVERY ROOM	0	703,296	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	419,339	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,628,235	54.00
60.00	06000	LABORATORY	0	2,994,167	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	925,575	65.00
65.01	06501	SLEEP LAB	0	65,923	65.01
66.00	06600	PHYSICAL THERAPY	0	979,732	66.00
69.00	06900	ELECTROCARDIOLOGY	0	275,259	69.00
69.01	06901	CARDIAC REHAB	0	65,672	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,374,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,276,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	76.00
76.01	03480	ONCOLOGY	0	1,667,892	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - FPC	0	1,113,935	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	1,342,698	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	-305,614	741,283	88.02
90.00	09000	CLINIC	0	161,408	90.00
90.01	09001	CLINIC- ORTHO	-1,262,820	258,843	90.01
90.02	09002	CLINIC - PEDS & ENT	-1,043,881	547,937	90.02
90.03	09003	IV THERAPY	0	2,510,600	90.03
90.04	09004	OP PSYCH	-392,952	177,499	90.04
91.00	09100	EMERGENCY	0	2,065,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	-48	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,561,859	61,807,710	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	70,031	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	194.00
194.01	07951	MOB	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	2,427	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	194.03
194.04	07954	EDUCATION	0	26,383	194.04
194.05	07955	MARKETING	0	1,036,342	194.05
194.06	07956	GUEST MEALS	0	14,475	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	194.07
194.08	07958	CANCER CENTER	0	0	194.08
194.09	07959	URGENT CARE	0	242,552	194.09
194.10	07960	RHC	0	0	194.10
194.11	07961	OBGYN	0	185,143	194.11
194.12	07962	TRINE STUDENT HEALTH	0	89,983	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	323,760	194.13
194.14	07964	IMMUNIZATION CLINIC	0	100,836	194.14
194.15	07965	FOUNDATION	0	401,143	194.15
194.16	07967	RETAIL PHARMACY	0	0	194.16

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.17	07966	FAMILY PRACTICE CENTER	0	320,853	194.17
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,561,859	64,621,638	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	672,324	62,033	1.00
2.00	NURSERY	43.00	52,830	4,874	2.00
3.00	EMERGENCY	91.00	2,879	266	3.00
	0		728,033	67,173	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53,193	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,904	2.00
	0		0	67,097	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	369,828	272,602	1.00
2.00	GUEST MEALS	194.06	8,333	6,142	2.00
	0		378,161	278,744	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,530,510	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27,801	2.00
	0		0	1,558,311	
	E - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,766,039	1.00
	0		0	1,766,039	
	F - ICU				
1.00	INTENSIVE CARE UNIT	31.00	92,308	24,240	1.00
	0		92,308	24,240	
	H - PROPERTY TAX				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,104	1.00
	0		0	22,104	
	J - SLEEP LAB - SALARIED STAFF				
1.00	SLEEP LAB	65.01	34,629	31,294	1.00
2.00	ELECTROCARDIOLOGY	69.00	10,082	259,746	2.00
	0		44,711	291,040	
	L - PUBLIC RELATIONS				
1.00	MARKETING	194.05	0	21,521	1.00
	0		0	21,521	
	N - RECOVERY ROOM				
1.00	RECOVERY ROOM	51.00	703,296	0	1.00
	0		703,296	0	
	O - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,276,176	1.00
	0		0	1,276,176	
	S - FOUNDATION RECLASS				
1.00	FOUNDATION	194.15	7,019	0	1.00
	0		7,019	0	
	T - IMMUNIZATION CLINIC RECLASS				
1.00	IMMUNIZATION CLINIC	194.14	0	80,565	1.00
	0		0	80,565	
	U - FAMILY PRACTICE - PROV BASED				
1.00	CLINIC - PEDS & ENT	90.02	385,907	9,291	1.00
	TOTALS		385,907	9,291	
	V - IV THERAPY				
1.00	IV THERAPY	90.03	0	2,360,744	1.00
	TOTALS		0	2,360,744	
	W - URGENT CARE - NON RHC				
1.00	URGENT CARE	194.09	214,023	28,529	1.00
	TOTALS		214,023	28,529	
	X - OB/GYN NON-RHC				
1.00	OBGYN	194.11	174,961	10,182	1.00
	TOTALS		174,961	10,182	
500.00	Grand Total: Increases		2,728,419	7,861,756	500.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-6 | Date/Time Prepared: 4/21/2021 9:44 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LABOR AND DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	728,033	67,173	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		728,033	67,173		
	B - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	67,097	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	67,097		
	C - CAFETERIA					
1.00	DIETARY	10.00	378,161	278,744	0	1.00
2.00		0.00	0	0	0	2.00
	0		378,161	278,744		
	D - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	1,558,311	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	1,558,311		
	E - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,766,039	9	1.00
	0		0	1,766,039		
	F - ICU					
1.00	ADULTS & PEDIATRICS	30.00	92,308	24,240	0	1.00
	0		92,308	24,240		
	H - PROPERTY TAX					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,104	13	1.00
	0		0	22,104		
	J - SLEEP LAB - SALARIED STAFF					
1.00	RESPIRATORY THERAPY	65.00	44,711	291,040	0	1.00
2.00		0.00	0	0	0	2.00
	0		44,711	291,040		
	L - PUBLIC RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,521	0	1.00
	0		0	21,521		
	N - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	703,296	0	0	1.00
	0		703,296	0		
	O - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,276,176	0	1.00
	0		0	1,276,176		
	S - FOUNDATION RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	7,019	0	0	1.00
	0		7,019	0		
	T - IMMUNIZATION CLINIC RECLASS					
1.00	PHARMACY	15.00	0	80,565	0	1.00
	0		0	80,565		
	U - FAMILY PRACTICE - PROV BASED					
1.00	FAMILY PRACTICE CENTER	194.17	385,907	9,291	0	1.00
	TOTALS		385,907	9,291		
	V - IV THERAPY					
1.00	PHARMACY	15.00	0	2,360,744	0	1.00
	TOTALS		0	2,360,744		
	W - URGENT CARE - NON RHC					
1.00	RURAL HEALTH CLINIC - URGENT CARE	88.01	214,023	28,529	0	1.00
	TOTALS		214,023	28,529		
	X - OB/GYN NON-RHC					
1.00	RURAL HEALTH CLINIC - OB/GYN	88.02	174,961	10,182	0	1.00
	TOTALS		174,961	10,182		
500.00	Grand Total: Decreases		2,728,419	7,861,756		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part I | Date/Time Prepared: 4/21/2021 9:44 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	1,419,368	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	58,020,916	283,730	0	283,730	706,401	3.00
4.00	Building Improvements	20,000	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	20,000,166	658,281	0	658,281	306,627	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,460,450	942,011	0	942,011	1,013,028	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	79,460,450	942,011	0	942,011	1,013,028	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,419,368	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	57,598,245	0	3.00
4.00	Building Improvements	20,000	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	20,351,820	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,389,433	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	79,389,433	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part II Date/Time Prepared: 4/21/2021 9:44 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	CAP REL COSTS-BLDG & FIXT	5,508,545	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,236,214	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,508,545	2,236,214	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	5,508,545	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,236,214	2.00
3.00	Total (sum of lines 1-2)	0	7,744,759	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part III | Date/Time Prepared: 4/21/2021 9:44 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	59,037,613	0	59,037,613	0.743646	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,351,820	0	20,351,820	0.256354	0	2.00
3.00	Total (sum of lines 1-2)	79,389,433	0	79,389,433	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,712,012	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,616,862	2,236,214	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,328,874	2,236,214	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	53,193	22,104	0	3,787,309	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,536	13,904	0	0	3,869,516	2.00
3.00	Total (sum of lines 1-2)	2,536	67,097	22,104	0	7,656,825	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8 | Date/Time Prepared: 4/21/2021 9:44 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-1,530,510	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-25,265	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	A	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)	B	-16,033	CAP REL COSTS-MVBLE EQUIP	2.00	9	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	-3,471,167			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	-362,110			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-181,971	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-8,330	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-515	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-8,519	CAFETERIA	11.00	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant	A	-167,753	CLINIC- ORTHO	90.01	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8 | Date/Time Prepared: 4/21/2021 9:44 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSES	A	-5,067	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	EMPLOYEE CHRISTMAS PARTY	A	-14,972	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN RECRUITMENT	A	-25,943	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MEALS ON WHEELS	B	-9,142	DIETARY	10.00	0	33.03
33.04	RENTAL INCOME OFFSET - CANCER CENTER	B	-30,494	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	ATM SURCHARGE REVENUE	B	-275	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	DIETICIAN CONSULTATIONS	B	-1,000	CAFETERIA	11.00	0	33.06
33.07	MIDLEVELS OFFSET	A	-140,371	CLINIC - PEDS & ENT	90.02	0	33.07
33.08	HAF EXPENSE	A	-2,248,200	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HC PHYSICIAN OFFSET	A	-305,614	RURAL HEALTH CLINIC - OB/GYN	88.02	0	33.09
33.11	MOVING EXPENSES	A	-8,560	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	CLEAR HOSPICE EXP	A	-48	HOSPICE	116.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,561,859				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 4/21/2021 9:44 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO - CAMERON WOODS BENEFITS	0	181,167	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CMO - CAMERON WOODS - A&G	0	30,300	2.00
3.00	7.00	OPERATION OF PLANT	CMO - CAMERON WOODS - CENTRA	0	3,300	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	CMO RENTAL	852,920	986,064	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO - RETAIL PHARMACY BENEFI	0	14,199	4.01
5.00	0		0	852,920	1,215,030	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	C	CAMERON MEDICAL	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 4/21/2021 9:44 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-181,167	0	1.00
2.00	-30,300	0	2.00
3.00	-3,300	0	3.00
4.00	-133,144	9	4.00
4.01	-14,199	0	4.01
5.00	-362,110		5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 4/21/2021 9:44 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	90.01	CLINIC- ORTHO	1,095,067	1,095,067	0	0	0	1.00
2.00	60.00	LABORATORY	3,539	0	3,539	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	588,041	537,899	50,142	0	0	3.00
4.00	50.00	OPERATING ROOM	541,739	541,739	0	0	0	4.00
5.00	90.02	DR. A	647,085	647,085	0	0	0	5.00
6.00	90.02	DR. B	108,934	108,934	0	0	0	6.00
7.00	90.02	DR. C	147,491	147,491	0	0	0	7.00
8.00	90.04	DR. D	392,952	392,952	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			3,524,848	3,471,167	53,681		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	90.01	CLINIC- ORTHO	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	90.02	DR. A	0	0	0	0	0	5.00
6.00	90.02	DR. B	0	0	0	0	0	6.00
7.00	90.02	DR. C	0	0	0	0	0	7.00
8.00	90.04	DR. D	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	90.01	CLINIC- ORTHO	0	0	0	1,095,067	1.00
2.00	60.00	LABORATORY	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	537,899	3.00
4.00	50.00	OPERATING ROOM	0	0	0	541,739	4.00
5.00	90.02	DR. A	0	0	0	647,085	5.00
6.00	90.02	DR. B	0	0	0	108,934	6.00
7.00	90.02	DR. C	0	0	0	147,491	7.00
8.00	90.04	DR. D	0	0	0	392,952	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	3,471,167	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,787,309	3,787,309				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,869,516		3,869,516			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,051,792	19,619	19,833	8,091,244		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,437,484	343,128	341,573	1,255,080	11,377,265	5.00
7.00	00700	OPERATION OF PLANT	3,256,685	335,646	342,440	269,914	4,204,685	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	40,675	35,314	25,562	0	101,551	8.00
9.00	00900	HOUSEKEEPING	1,233,991	5,985	4,333	225,217	1,469,526	9.00
10.00	01000	DIETARY	253,097	146,608	106,123	44,361	550,189	10.00
11.00	01100	CAFETERIA	450,940	66,005	47,778	108,674	673,397	11.00
13.00	01300	NURSING ADMINISTRATION	1,370,329	28,929	47,128	233,396	1,679,782	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	327,812	103,613	75,001	58,999	565,425	14.00
15.00	01500	PHARMACY	1,618,171	38,406	27,800	154,418	1,838,795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	608,832	0	26,645	148,863	784,340	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,575,332	550,888	398,766	821,966	5,346,952	30.00
31.00	03100	INTENSIVE CARE UNIT	116,548	39,237	28,402	27,125	211,312	31.00
43.00	04300	NURSERY	57,704	13,966	10,109	15,524	97,303	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,456,092	365,174	264,333	235,932	2,321,531	50.00
51.00	05100	RECOVERY ROOM	703,296	236,322	171,063	206,664	1,317,345	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	419,339	116,715	84,485	113,423	733,962	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,628,235	279,617	202,402	509,035	3,619,289	54.00
60.00	06000	LABORATORY	2,994,167	92,241	66,769	311,280	3,464,457	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	925,575	24,274	17,571	262,785	1,230,205	65.00
65.01	06501	SLEEP LAB	65,923	0	62,581	10,176	138,680	65.01
66.00	06600	PHYSICAL THERAPY	979,732	208,058	150,604	281,543	1,619,937	66.00
69.00	06900	ELECTROCARDIOLOGY	275,259	12,536	9,074	2,963	299,832	69.00
69.01	06901	CARDIAC REHAB	65,672	19,286	13,960	17,096	116,014	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,374,753	0	0	0	1,374,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,276,176	0	0	0	1,276,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	1,667,892	369,098	267,174	0	2,304,164	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	1,113,935	0	163,409	304,441	1,581,785	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	1,342,698	0	130,650	348,146	1,821,494	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	741,283	0	71,511	290,713	1,103,507	88.02
90.00	09000	CLINIC	161,408	0	12,805	40,335	214,548	90.00
90.01	09001	CLINIC- ORTHO	258,843	0	95,701	119,843	474,387	90.01
90.02	09002	CLINIC - PEDS & ENT	547,937	0	143,937	456,347	1,148,221	90.02
90.03	09003	IV THERAPY	2,510,600	16,959	12,276	40,142	2,579,977	90.03
90.04	09004	OP PSYCH	177,499	0	42,531	164,043	384,073	90.04
91.00	09100	EMERGENCY	2,065,179	300,399	217,446	541,602	3,124,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,807,710	3,768,023	3,701,775	7,620,046	61,149,485	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,286	13,960	0	33,246	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	70,031	0	0	17,494	87,525	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	2,427	0	0	0	2,427	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	26,383	0	0	721	27,104	194.04
194.05	07955	MARKETING	1,036,342	0	24,479	102,496	1,163,317	194.05
194.06	07956	GUEST MEALS	14,475	0	0	2,449	16,924	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	242,552	0	23,588	62,891	329,031	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	185,143	0	12,637	51,412	249,192	194.11
194.12	07962	TRINE STUDENT HEALTH	89,983	0	0	25,867	115,850	194.12

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.13	07963	OCCUPATIONAL HEALTH	323,760	0	20,387	70,796	414,943	194.13
194.14	07964	IMMUNIZATION CLINIC	100,836	0	2,912	5,668	109,416	194.14
194.15	07965	FOUNDATION	401,143	0	2,407	39,338	442,888	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	320,853	0	67,371	92,066	480,290	194.17
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)	64,621,638	3,787,309	3,869,516	8,091,244	64,621,638	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,377,265					5.00
7.00	00700	OPERATION OF PLANT	898,457	5,103,142				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,699	42,103	165,353			8.00
9.00	00900	HOUSEKEEPING	314,008	7,136	33,531	1,824,201		9.00
10.00	01000	DIETARY	117,564	174,793	108	22,771	865,425	10.00
11.00	01100	CAFETERIA	143,891	78,695	272	56,927	0	11.00
13.00	01300	NURSING ADMINISTRATION	358,936	77,624	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,820	123,533	0	14,337	0	14.00
15.00	01500	PHARMACY	392,914	45,790	0	16,024	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	167,598	43,887	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,142,546	656,792	37,959	575,178	825,283	30.00
31.00	03100	INTENSIVE CARE UNIT	45,153	46,781	935	5,904	40,142	31.00
43.00	04300	NURSERY	20,792	16,651	6,196	96,987	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	496,065	435,378	13,273	134,939	0	50.00
51.00	05100	RECOVERY ROOM	281,490	281,755	8,590	87,288	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	156,833	139,153	2,465	26,144	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,370	333,372	15,982	142,529	0	54.00
60.00	06000	LABORATORY	740,285	109,974	799	84,758	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	262,870	28,941	143	24,879	0	65.00
65.01	06501	SLEEP LAB	29,633	103,076	2,842	30,361	0	65.01
66.00	06600	PHYSICAL THERAPY	346,148	248,057	2,741	64,939	0	66.00
69.00	06900	ELECTROCARDIOLOGY	64,068	14,946	0	0	0	69.00
69.01	06901	CARDIAC REHAB	24,790	22,994	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	293,757	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	272,693	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	492,354	440,056	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	337,996	269,148	1,932	78,433	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	389,217	215,191	2,480	3,373	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	235,797	117,784	455	22,771	0	88.02
90.00	09000	CLINIC	45,845	21,091	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	101,367	157,627	699	35,000	0	90.01
90.02	09002	CLINIC - PEDS & ENT	245,352	237,075	914	45,963	0	90.02
90.03	09003	IV THERAPY	551,289	20,219	1,731	13,494	0	90.03
90.04	09004	OP PSYCH	82,069	70,052	0	0	0	90.04
91.00	09100	EMERGENCY	667,670	358,150	30,632	240,359	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,635,336	4,937,824	164,679	1,823,358	865,425	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,104	22,994	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,702	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	519	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	5,792	0	0	0	0	194.04
194.05	07955	MARKETING	248,578	40,319	0	0	0	194.05
194.06	07956	GUEST MEALS	3,616	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	70,307	38,852	674	843	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	53,247	20,813	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	24,755	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	88,665	33,579	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	23,380	4,797	0	0	0	194.14
194.15	07965	FOUNDATION	94,636	3,964	0	0	0	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	102,628	0	0	0	0	194.17

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 4/21/2021 9:44 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	11,377,265	5,103,142	165,353	1,824,201	865,425	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	953,182					11.00
13.00	01300	NURSING ADMINISTRATION	31,405	2,147,747				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,467	0	843,582			14.00
15.00	01500	PHARMACY	21,520	0	3,888	2,318,931		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,268	0	60	0	1,039,153	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	172,614	927,056	21,095	0	7,427	30.00
31.00	03100	INTENSIVE CARE UNIT	6,159	33,115	916	0	529	31.00
43.00	04300	NURSERY	2,395	12,949	0	0	105	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,655	266,764	65,995	0	17,773	50.00
51.00	05100	RECOVERY ROOM	36,500	195,979	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,098	97,126	10,716	0	692	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,330	0	12,323	0	173,321	54.00
60.00	06000	LABORATORY	79,540	0	176,430	0	312,843	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	48,743	0	6,048	0	13,061	65.00
65.01	06501	SLEEP LAB	798	0	0	0	11,027	65.01
66.00	06600	PHYSICAL THERAPY	56,157	0	1,841	0	66,972	66.00
69.00	06900	ELECTROCARDIOLOGY	3,118	0	702	0	45,726	69.00
69.01	06901	CARDIAC REHAB	4,068	0	357	0	15,445	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	247,884	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	230,109	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,318,931	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	0	1,206	0	71,873	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	0	19,644	0	11,898	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	20,455	0	1,524	0	31,711	88.02
90.00	09000	CLINIC	9,733	52,357	3,625	0	30,140	90.00
90.01	09001	CLINIC- ORTHO	24,333	0	1,800	0	25,546	90.01
90.02	09002	CLINIC - PEDS & ENT	48,515	0	2,151	0	50,962	90.02
90.03	09003	IV THERAPY	6,844	0	2,302	0	0	90.03
90.04	09004	OP PSYCH	18,098	0	118	0	22,533	90.04
91.00	09100	EMERGENCY	104,709	562,401	24,245	0	110,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	920,522	2,147,747	834,979	2,318,931	1,019,922	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	17,490	0	810	0	0	194.05
194.06	07956	GUEST MEALS	912	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	3,549	0	2,150	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	14,258	0	270	0	5,609	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	347	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	704	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	168	0	0	194.14
194.15	07965	FOUNDATION	0	0	2,401	0	0	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.17	07966	FAMILY PRACTICE CENTER	0	0	354	0	11,472	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	953,182	2,147,747	843,582	2,318,931	1,039,153	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	9,712,902	0	9,712,902		30.00
31.00	03100	INTENSIVE CARE UNIT	390,946	0	390,946		31.00
43.00	04300	NURSERY	253,378	0	253,378		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,801,373	0	3,801,373		50.00
51.00	05100	RECOVERY ROOM	2,208,947	0	2,208,947		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,185,189	0	1,185,189		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,164,516	0	5,164,516		54.00
60.00	06000	LABORATORY	4,969,086	0	4,969,086		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,614,890	0	1,614,890		65.00
65.01	06501	SLEEP LAB	316,417	0	316,417		65.01
66.00	06600	PHYSICAL THERAPY	2,406,792	0	2,406,792		66.00
69.00	06900	ELECTROCARDIOLOGY	428,392	0	428,392		69.00
69.01	06901	CARDIAC REHAB	183,668	0	183,668		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,916,394	0	1,916,394		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,778,978	0	1,778,978		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,318,931	0	2,318,931		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	3,236,574	0	3,236,574		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC - FPC	2,342,373	0	2,342,373		88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	2,463,297	0	2,463,297		88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	1,534,004	0	1,534,004		88.02
90.00	09000	CLINIC	377,339	0	377,339		90.00
90.01	09001	CLINIC- ORTHO	820,759	0	820,759		90.01
90.02	09002	CLINIC - PEDS & ENT	1,779,153	0	1,779,153		90.02
90.03	09003	IV THERAPY	3,175,856	0	3,175,856		90.03
90.04	09004	OP PSYCH	576,943	0	576,943		90.04
91.00	09100	EMERGENCY	5,223,130	0	5,223,130		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,180,227	0	60,180,227		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,344	0	63,344		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	106,227	0	106,227		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	2,946	0	2,946		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	32,896	0	32,896		194.04
194.05	07955	MARKETING	1,470,514	0	1,470,514		194.05
194.06	07956	GUEST MEALS	21,452	0	21,452		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	445,406	0	445,406		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	343,389	0	343,389		194.11
194.12	07962	TRINE STUDENT HEALTH	140,952	0	140,952		194.12
194.13	07963	OCCUPATIONAL HEALTH	537,891	0	537,891		194.13
194.14	07964	IMMUNIZATION CLINIC	137,761	0	137,761		194.14

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.15	07965	FOUNDATION	543,889	0	543,889	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	594,744	0	594,744	194.17
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	64,621,638	0	64,621,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,619	19,833	39,452	39,452	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	343,128	341,573	684,701	6,114	5.00
7.00	00700	OPERATION OF PLANT	0	335,646	342,440	678,086	1,316	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,314	25,562	60,876	0	8.00
9.00	00900	HOUSEKEEPING	0	5,985	4,333	10,318	1,098	9.00
10.00	01000	DIETARY	0	146,608	106,123	252,731	216	10.00
11.00	01100	CAFETERIA	0	66,005	47,778	113,783	530	11.00
13.00	01300	NURSING ADMINISTRATION	0	28,929	47,128	76,057	1,138	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	103,613	75,001	178,614	288	14.00
15.00	01500	PHARMACY	0	38,406	27,800	66,206	753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	26,645	26,645	726	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	550,888	398,766	949,654	4,008	30.00
31.00	03100	INTENSIVE CARE UNIT	0	39,237	28,402	67,639	132	31.00
43.00	04300	NURSERY	0	13,966	10,109	24,075	76	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	365,174	264,333	629,507	1,151	50.00
51.00	05100	RECOVERY ROOM	0	236,322	171,063	407,385	1,008	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	116,715	84,485	201,200	553	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	279,617	202,402	482,019	2,482	54.00
60.00	06000	LABORATORY	0	92,241	66,769	159,010	1,518	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	24,274	17,571	41,845	1,282	65.00
65.01	06501	SLEEP LAB	0	0	62,581	62,581	50	65.01
66.00	06600	PHYSICAL THERAPY	0	208,058	150,604	358,662	1,373	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,536	9,074	21,610	14	69.00
69.01	06901	CARDIAC REHAB	0	19,286	13,960	33,246	83	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	369,098	267,174	636,272	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	0	163,409	163,409	1,485	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	0	130,650	130,650	1,698	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	0	71,511	71,511	1,418	88.02
90.00	09000	CLINIC	0	0	12,805	12,805	197	90.00
90.01	09001	CLINIC- ORTHO	0	0	95,701	95,701	584	90.01
90.02	09002	CLINIC - PEDS & ENT	0	0	143,937	143,937	2,225	90.02
90.03	09003	IV THERAPY	0	16,959	12,276	29,235	196	90.03
90.04	09004	OP PSYCH	0	0	42,531	42,531	800	90.04
91.00	09100	EMERGENCY	0	300,399	217,446	517,845	2,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,768,023	3,701,775	7,469,798	37,153	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,286	13,960	33,246	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	85	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	4	194.04
194.05	07955	MARKETING	0	0	24,479	24,479	500	194.05
194.06	07956	GUEST MEALS	0	0	0	0	12	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	23,588	23,588	307	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	12,637	12,637	251	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	126	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	20,387	20,387	345	194.13

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.14	07964	IMMUNIZATION CLINIC	0	0	2,912	2,912	28	194.14
194.15	07965	FOUNDATION	0	0	2,407	2,407	192	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	0	0	67,371	67,371	449	194.17
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	3,787,309	3,869,516	7,656,825	39,452	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	690,815					5.00
7.00	00700	OPERATION OF PLANT	54,552	733,954				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,318	6,055	68,249			8.00
9.00	00900	HOUSEKEEPING	19,066	1,026	13,840	45,348		9.00
10.00	01000	DIETARY	7,138	25,139	44	566	285,834	10.00
11.00	01100	CAFETERIA	8,737	11,318	112	1,415	0	11.00
13.00	01300	NURSING ADMINISTRATION	21,793	11,164	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,336	17,767	0	356	0	14.00
15.00	01500	PHARMACY	23,857	6,586	0	398	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,176	6,312	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,391	94,462	15,670	14,300	272,576	30.00
31.00	03100	INTENSIVE CARE UNIT	2,742	6,728	386	147	13,258	31.00
43.00	04300	NURSERY	1,262	2,395	2,557	2,411	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,120	62,618	5,478	3,354	0	50.00
51.00	05100	RECOVERY ROOM	17,091	40,523	3,545	2,170	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,522	20,014	1,018	650	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,957	47,947	6,597	3,543	0	54.00
60.00	06000	LABORATORY	44,948	15,817	330	2,107	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	15,961	4,162	59	618	0	65.00
65.01	06501	SLEEP LAB	1,799	14,825	1,173	755	0	65.01
66.00	06600	PHYSICAL THERAPY	21,017	35,677	1,131	1,614	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,890	2,150	0	0	0	69.00
69.01	06901	CARDIAC REHAB	1,505	3,307	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,836	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,557	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	29,894	63,291	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	20,522	38,710	797	1,950	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	23,632	30,950	1,024	84	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	14,317	16,940	188	566	0	88.02
90.00	09000	CLINIC	2,784	3,033	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	6,155	22,671	288	870	0	90.01
90.02	09002	CLINIC - PEDS & ENT	14,897	34,097	377	1,143	0	90.02
90.03	09003	IV THERAPY	33,473	2,908	714	335	0	90.03
90.04	09004	OP PSYCH	4,983	10,075	0	0	0	90.04
91.00	09100	EMERGENCY	40,539	51,511	12,643	5,975	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	645,767	710,178	67,971	45,327	285,834	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	431	3,307	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,136	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	31	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	352	0	0	0	0	194.04
194.05	07955	MARKETING	15,093	5,799	0	0	0	194.05
194.06	07956	GUEST MEALS	220	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	4,269	5,588	278	21	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	3,233	2,993	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	1,503	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	5,383	4,829	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	1,420	690	0	0	0	194.14
194.15	07965	FOUNDATION	5,746	570	0	0	0	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	6,231	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II Date/Time Prepared: 4/21/2021 9:44 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	690,815	733,954	68,249	45,348	285,834	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	135,895					11.00
13.00	01300	NURSING ADMINISTRATION	4,477	114,629				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,775	0	207,136			14.00
15.00	01500	PHARMACY	3,068	0	955	101,823		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,169	0	15	0	50,043	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,612	49,479	5,180	0	358	30.00
31.00	03100	INTENSIVE CARE UNIT	878	1,767	225	0	25	31.00
43.00	04300	NURSERY	341	691	0	0	5	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,079	14,238	16,205	0	856	50.00
51.00	05100	RECOVERY ROOM	5,204	10,460	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,580	5,184	2,631	0	33	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,449	0	3,026	0	8,347	54.00
60.00	06000	LABORATORY	11,340	0	43,321	0	15,067	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,949	0	1,485	0	629	65.00
65.01	06501	SLEEP LAB	114	0	0	0	531	65.01
66.00	06600	PHYSICAL THERAPY	8,006	0	452	0	3,225	66.00
69.00	06900	ELECTROCARDIOLOGY	444	0	172	0	2,202	69.00
69.01	06901	CARDIAC REHAB	580	0	88	0	744	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	60,868	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	56,501	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	101,823	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	0	296	0	3,461	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	0	4,823	0	573	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	2,916	0	374	0	1,527	88.02
90.00	09000	CLINIC	1,388	2,794	890	0	1,451	90.00
90.01	09001	CLINIC- ORTHO	3,469	0	442	0	1,230	90.01
90.02	09002	CLINIC - PEDS & ENT	6,917	0	528	0	2,454	90.02
90.03	09003	IV THERAPY	976	0	565	0	0	90.03
90.04	09004	OP PSYCH	2,580	0	29	0	1,085	90.04
91.00	09100	EMERGENCY	14,928	30,016	5,953	0	5,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,239	114,629	205,024	101,823	49,117	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	2,493	0	199	0	0	194.05
194.06	07956	GUEST MEALS	130	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	871	0	104	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	2,033	0	66	0	270	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	85	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	173	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	41	0	0	194.14
194.15	07965	FOUNDATION	0	0	590	0	0	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.17	07966	FAMILY PRACTICE CENTER	0	0	87	0	552	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	135,895	114,629	207,136	101,823	50,043	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,499,690	0	1,499,690	30.00
31.00	03100	INTENSIVE CARE UNIT	93,927	0	93,927	31.00
43.00	04300	NURSERY	33,813	0	33,813	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	770,606	0	770,606	50.00
51.00	05100	RECOVERY ROOM	487,386	0	487,386	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	243,385	0	243,385	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	614,367	0	614,367	54.00
60.00	06000	LABORATORY	293,458	0	293,458	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	72,990	0	72,990	65.00
65.01	06501	SLEEP LAB	81,828	0	81,828	65.01
66.00	06600	PHYSICAL THERAPY	431,157	0	431,157	66.00
69.00	06900	ELECTROCARDIOLOGY	30,482	0	30,482	69.00
69.01	06901	CARDIAC REHAB	39,553	0	39,553	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,704	0	78,704	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,058	0	73,058	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,823	0	101,823	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	76.00
76.01	03480	ONCOLOGY	729,457	0	729,457	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - FPC	230,630	0	230,630	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	193,434	0	193,434	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	109,757	0	109,757	88.02
90.00	09000	CLINIC	25,342	0	25,342	90.00
90.01	09001	CLINIC- ORTHO	131,410	0	131,410	90.01
90.02	09002	CLINIC - PEDS & ENT	206,575	0	206,575	90.02
90.03	09003	IV THERAPY	68,402	0	68,402	90.03
90.04	09004	OP PSYCH	62,083	0	62,083	90.04
91.00	09100	EMERGENCY	687,365	0	687,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,390,682	0	7,390,682	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,984	0	36,984	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,221	0	1,221	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	194.00
194.01	07951	MOB	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	31	0	31	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	194.03
194.04	07954	EDUCATION	356	0	356	194.04
194.05	07955	MARKETING	48,563	0	48,563	194.05
194.06	07956	GUEST MEALS	362	0	362	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	194.08
194.09	07959	URGENT CARE	35,026	0	35,026	194.09
194.10	07960	RHC	0	0	0	194.10
194.11	07961	OBGYN	21,483	0	21,483	194.11
194.12	07962	TRINE STUDENT HEALTH	1,714	0	1,714	194.12
194.13	07963	OCCUPATIONAL HEALTH	31,117	0	31,117	194.13
194.14	07964	IMMUNIZATION CLINIC	5,091	0	5,091	194.14

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
194.15	07965	FOUNDATION	9,505	0	9,505	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	74,690	0	74,690	194.17
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,656,825	0	7,656,825	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	113,897					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		160,763				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	590	824	27,535,197			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,319	14,191	4,271,136	-11,377,265	53,244,373	5.00
7.00	00700	OPERATION OF PLANT	10,094	14,227	918,541	0	4,204,685	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	101,551	8.00
9.00	00900	HOUSEKEEPING	180	180	766,434	0	1,469,526	9.00
10.00	01000	DIETARY	4,409	4,409	150,963	0	550,189	10.00
11.00	01100	CAFETERIA	1,985	1,985	369,828	0	673,397	11.00
13.00	01300	NURSING ADMINISTRATION	870	1,958	794,268	0	1,679,782	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	200,780	0	565,425	14.00
15.00	01500	PHARMACY	1,155	1,155	525,496	0	1,838,795	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,107	506,595	0	784,340	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,567	16,567	2,797,220	0	5,346,952	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	92,308	0	211,312	31.00
43.00	04300	NURSERY	420	420	52,830	0	97,303	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	10,982	802,896	0	2,321,531	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	703,296	0	1,317,345	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,510	3,510	385,987	0	733,962	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	8,409	1,732,290	0	3,619,289	54.00
60.00	06000	LABORATORY	2,774	2,774	1,059,314	0	3,464,457	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	730	730	894,281	0	1,230,205	65.00
65.01	06501	SLEEP LAB	0	2,600	34,629	0	138,680	65.01
66.00	06600	PHYSICAL THERAPY	6,257	6,257	958,116	0	1,619,937	66.00
69.00	06900	ELECTROCARDIOLOGY	377	377	10,082	0	299,832	69.00
69.01	06901	CARDIAC REHAB	580	580	58,178	0	116,014	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,374,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,276,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	11,100	11,100	0	0	2,304,164	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	6,789	1,036,038	0	1,581,785	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	5,428	1,184,770	0	1,821,494	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	2,971	989,322	0	1,103,507	88.02
90.00	09000	CLINIC	0	532	137,264	0	214,548	90.00
90.01	09001	CLINIC- ORTHO	0	3,976	407,837	0	474,387	90.01
90.02	09002	CLINIC - PEDS & ENT	0	5,980	1,552,989	0	1,148,221	90.02
90.03	09003	IV THERAPY	510	510	136,606	0	2,579,977	90.03
90.04	09004	OP PSYCH	0	1,767	558,254	0	384,073	90.04
91.00	09100	EMERGENCY	9,034	9,034	1,843,119	0	3,124,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,317	153,794	25,931,667	-11,377,265	49,772,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	580	0	0	33,246	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	59,534	0	87,525	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	2,427	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	2,452	0	27,104	194.04
194.05	07955	MARKETING	0	1,017	348,803	0	1,163,317	194.05
194.06	07956	GUEST MEALS	0	0	8,333	0	16,924	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	980	214,023	0	329,031	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	525	174,961	0	249,192	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	88,029	0	115,850	194.12

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
194.13	07963	OCCUPATIONAL HEALTH	0	847	240,924	0	414,943	194.13
194.14	07964	IMMUNIZATION CLINIC	0	121	19,290	0	109,416	194.14
194.15	07965	FOUNDATION	0	100	133,871	0	442,888	194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	0	2,799	313,310	0	480,290	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,787,309	3,869,516	8,091,244		11,377,265	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.252052	24.069693	0.293851		0.213680	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			39,452		690,815	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001433		0.012974	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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	128,722					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	46,143				8.00
9.00	00900	HOUSEKEEPING	180	9,357	4,326			9.00
10.00	01000	DIETARY	4,409	30	54	12,763		10.00
11.00	01100	CAFETERIA	1,985	76	135	0	25,070	11.00
13.00	01300	NURSING ADMINISTRATION	1,958	0	0	0	826	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	0	34	0	512	14.00
15.00	01500	PHARMACY	1,155	0	38	0	566	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,107	0	0	0	1,138	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,567	10,593	1,364	12,171	4,540	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	261	14	592	162	31.00
43.00	04300	NURSERY	420	1,729	230	0	63	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	3,704	320	0	1,306	50.00
51.00	05100	RECOVERY ROOM	7,107	2,397	207	0	960	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,510	688	62	0	476	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	4,460	338	0	2,481	54.00
60.00	06000	LABORATORY	2,774	223	201	0	2,092	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	730	40	59	0	1,282	65.00
65.01	06501	SLEEP LAB	2,600	793	72	0	21	65.01
66.00	06600	PHYSICAL THERAPY	6,257	765	154	0	1,477	66.00
69.00	06900	ELECTROCARDIOLOGY	377	0	0	0	82	69.00
69.01	06901	CARDIAC REHAB	580	0	0	0	107	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	11,100	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	6,789	539	186	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	5,428	692	8	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	2,971	127	54	0	538	88.02
90.00	09000	CLINIC	532	0	0	0	256	90.00
90.01	09001	CLINIC- ORTHO	3,976	195	83	0	640	90.01
90.02	09002	CLINIC - PEDS & ENT	5,980	255	109	0	1,276	90.02
90.03	09003	IV THERAPY	510	483	32	0	180	90.03
90.04	09004	OP PSYCH	1,767	0	0	0	476	90.04
91.00	09100	EMERGENCY	9,034	8,548	570	0	2,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,552	45,955	4,324	12,763	24,211	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	1,017	0	0	0	460	194.05
194.06	07956	GUEST MEALS	0	0	0	0	24	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	980	188	2	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	525	0	0	0	375	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	847	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	121	0	0	0	0	194.14
194.15	07965	FOUNDATION	100	0	0	0	0	194.15

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
194.16	07967	RETAIL PHARMACY	0	0	0	0	0	194.16
194.17	07966	FAMILY PRACTICE CENTER	0	0	0	0	0	194.17
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)	5,103,142	165,353	1,824,201	865,425	953,182	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.644676	3.583490	421.683079	67.807334	38.020822	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	733,954	68,249	45,348	285,834	135,895	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.701854	1.479076	10.482663	22.395518	5.420622	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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	218,765					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,678,476				14.00
15.00	01500	PHARMACY	0	21,564	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	332	0	624,482		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,428	116,993	0	4,463		30.00
31.00	03100	INTENSIVE CARE UNIT	3,373	5,082	0	318		31.00
43.00	04300	NURSERY	1,319	0	0	63		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,172	366,007	0	10,681		50.00
51.00	05100	RECOVERY ROOM	19,962	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,893	59,433	0	416		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68,341	0	104,158		54.00
60.00	06000	LABORATORY	0	978,478	0	188,003		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	33,540	0	7,849		65.00
65.01	06501	SLEEP LAB	0	0	0	6,627		65.01
66.00	06600	PHYSICAL THERAPY	0	10,210	0	40,247		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,895	0	27,479		69.00
69.01	06901	CARDIAC REHAB	0	1,979	0	9,282		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,374,753	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,276,176	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	6,690	0	43,192		88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	108,946	0	7,150		88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	8,452	0	19,057		88.02
90.00	09000	CLINIC	5,333	20,104	0	18,113		90.00
90.01	09001	CLINIC- ORTHO	0	9,983	0	15,352		90.01
90.02	09002	CLINIC - PEDS & ENT	0	11,932	0	30,626		90.02
90.03	09003	IV THERAPY	0	12,767	0	0		90.03
90.04	09004	OP PSYCH	0	652	0	13,541		90.04
91.00	09100	EMERGENCY	57,285	134,462	0	66,308		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	218,765	4,630,771	100	612,925		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	4,490	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	19,680	0	1,292		194.09
194.10	07960	RHC	0	0	0	0		194.10
194.11	07961	OBGYN	0	1,495	0	3,371		194.11
194.12	07962	TRINE STUDENT HEALTH	0	1,922	0	0		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	3,905	0	0		194.13
194.14	07964	IMMUNIZATION CLINIC	0	933	0	0		194.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/21/2021 9:44 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
194.15	07965	FOUNDATION	0	13,318	0	0		194.15
194.16	07967	RETAIL PHARMACY	0	0	0	0		194.16
194.17	07966	FAMILY PRACTICE CENTER	0	1,962	0	6,894		194.17
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)	2,147,747	843,582	2,318,931	1,039,153		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.817599	0.180311	23,189.310000	1.664024		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	114,629	207,136	101,823	50,043		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.523982	0.044274	1,018.230000	0.080135		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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/21/2021 9:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	9,712,902		9,712,902	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	390,946		390,946	0	0	31.00
43.00	04300	NURSERY	253,378		253,378	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,801,373		3,801,373	0	0	50.00
51.00	05100	RECOVERY ROOM	2,208,947		2,208,947	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,185,189		1,185,189	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,164,516		5,164,516	0	0	54.00
60.00	06000	LABORATORY	4,969,086		4,969,086	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,614,890	0	1,614,890	0	0	65.00
65.01	06501	SLEEP LAB	316,417	0	316,417	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,406,792	0	2,406,792	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	428,392		428,392	0	0	69.00
69.01	06901	CARDIAC REHAB	183,668		183,668	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,916,394		1,916,394	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,778,978		1,778,978	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,318,931		2,318,931	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	3,236,574		3,236,574	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	2,342,373		2,342,373	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	2,463,297		2,463,297	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	1,534,004		1,534,004	0	0	88.02
90.00	09000	CLINIC	377,339		377,339	0	0	90.00
90.01	09001	CLINIC- ORTHO	820,759		820,759	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	1,779,153		1,779,153	0	0	90.02
90.03	09003	IV THERAPY	3,175,856		3,175,856	0	0	90.03
90.04	09004	OP PSYCH	576,943		576,943	0	0	90.04
91.00	09100	EMERGENCY	5,223,130		5,223,130	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,731,983		2,731,983		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	62,912,210	0	62,912,210	0	0	200.00
201.00		Less Observation Beds	2,731,983		2,731,983		0	201.00
202.00		Total (see instructions)	60,180,227	0	60,180,227	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/21/2021 9:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	8,342,495		8,342,495			30.00
31.00	03100	INTENSIVE CARE UNIT	380,000		380,000			31.00
43.00	04300	NURSERY	445,000		445,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,872,642	14,478,256	17,350,898	0.219088	0.000000	50.00
51.00	05100	RECOVERY ROOM	715,418	3,505,207	4,220,625	0.523370	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,360,895	380,357	1,741,252	0.680653	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,886,115	31,864,603	33,750,718	0.153019	0.000000	54.00
60.00	06000	LABORATORY	2,312,689	17,375,132	19,687,821	0.252394	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,513,234	907,226	2,420,460	0.667183	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,053,550	1,053,550	0.300334	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	660,361	3,486,028	4,146,389	0.580455	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	230,676	1,893,617	2,124,293	0.201663	0.000000	69.00
69.01	06901	CARDIAC REHAB	1,870	369,189	371,059	0.494983	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	557,450	2,360,939	2,918,389	0.656662	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	568,473	1,767,355	2,335,828	0.761605	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,808,515	5,156,476	6,964,991	0.332941	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	16,741,255	16,741,255	0.193329	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	16,401	1,225,068	1,241,469			88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	2,781,006	2,781,006			88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	1,020,616	1,020,616			88.02
90.00	09000	CLINIC	0	565,123	565,123	0.667711	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	374,109	374,109	2.193903	0.000000	90.01
90.02	09002	CLINIC - PEDS & ENT	2,884	1,144,726	1,147,610	1.550312	0.000000	90.02
90.03	09003	IV THERAPY	0	8,317,896	8,317,896	0.381810	0.000000	90.03
90.04	09004	OP PSYCH	0	258,008	258,008	2.236144	0.000000	90.04
91.00	09100	EMERGENCY	474,191	19,749,819	20,224,010	0.258264	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	70,653	1,836,245	1,906,898	1.432684	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	24,219,962	138,611,806	162,831,768			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,219,962	138,611,806	162,831,768			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/21/2021 9:44 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
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	06501	SLEEP LAB	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHAB	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	76.00
76.01	03480	ONCOLOGY	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC - FPC		88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE		88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN		88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0.000000	90.01
90.02	09002	CLINIC - PEDS & ENT	0.000000	90.02
90.03	09003	IV THERAPY	0.000000	90.03
90.04	09004	OP PSYCH	0.000000	90.04
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		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	9,712,902		9,712,902	0	9,712,902	30.00
31.00	03100	INTENSIVE CARE UNIT	390,946		390,946	0	390,946	31.00
43.00	04300	NURSERY	253,378		253,378	0	253,378	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,801,373		3,801,373	0	3,801,373	50.00
51.00	05100	RECOVERY ROOM	2,208,947		2,208,947	0	2,208,947	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,185,189		1,185,189	0	1,185,189	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,164,516		5,164,516	0	5,164,516	54.00
60.00	06000	LABORATORY	4,969,086		4,969,086	0	4,969,086	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,614,890	0	1,614,890	0	1,614,890	65.00
65.01	06501	SLEEP LAB	316,417	0	316,417	0	316,417	65.01
66.00	06600	PHYSICAL THERAPY	2,406,792	0	2,406,792	0	2,406,792	66.00
69.00	06900	ELECTROCARDIOLOGY	428,392		428,392	0	428,392	69.00
69.01	06901	CARDIAC REHAB	183,668		183,668	0	183,668	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,916,394		1,916,394	0	1,916,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,778,978		1,778,978	0	1,778,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,318,931		2,318,931	0	2,318,931	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	3,236,574		3,236,574	0	3,236,574	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	2,342,373		2,342,373	0	2,342,373	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	2,463,297		2,463,297	0	2,463,297	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	1,534,004		1,534,004	0	1,534,004	88.02
90.00	09000	CLINIC	377,339		377,339	0	377,339	90.00
90.01	09001	CLINIC- ORTHO	820,759		820,759	0	820,759	90.01
90.02	09002	CLINIC - PEDS & ENT	1,779,153		1,779,153	0	1,779,153	90.02
90.03	09003	IV THERAPY	3,175,856		3,175,856	0	3,175,856	90.03
90.04	09004	OP PSYCH	576,943		576,943	0	576,943	90.04
91.00	09100	EMERGENCY	5,223,130		5,223,130	0	5,223,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,731,983		2,731,983		2,731,983	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	62,912,210	0	62,912,210	0	62,912,210	200.00
201.00		Less Observation Beds	2,731,983		2,731,983		2,731,983	201.00
202.00		Total (see instructions)	60,180,227	0	60,180,227	0	60,180,227	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	8,342,495		8,342,495			30.00
31.00	03100	INTENSIVE CARE UNIT	380,000		380,000			31.00
43.00	04300	NURSERY	445,000		445,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,872,642	14,478,256	17,350,898	0.219088	0.000000	50.00
51.00	05100	RECOVERY ROOM	715,418	3,505,207	4,220,625	0.523370	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,360,895	380,357	1,741,252	0.680653	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,886,115	31,864,603	33,750,718	0.153019	0.000000	54.00
60.00	06000	LABORATORY	2,312,689	17,375,132	19,687,821	0.252394	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,513,234	907,226	2,420,460	0.667183	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,053,550	1,053,550	0.300334	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	660,361	3,486,028	4,146,389	0.580455	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	230,676	1,893,617	2,124,293	0.201663	0.000000	69.00
69.01	06901	CARDIAC REHAB	1,870	369,189	371,059	0.494983	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	557,450	2,360,939	2,918,389	0.656662	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	568,473	1,767,355	2,335,828	0.761605	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,808,515	5,156,476	6,964,991	0.332941	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	16,741,255	16,741,255	0.193329	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	16,401	1,225,068	1,241,469	1.886775	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	2,781,006	2,781,006	0.885758	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	1,020,616	1,020,616	1.503018	0.000000	88.02
90.00	09000	CLINIC	0	565,123	565,123	0.667711	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	374,109	374,109	2.193903	0.000000	90.01
90.02	09002	CLINIC - PEDS & ENT	2,884	1,144,726	1,147,610	1.550312	0.000000	90.02
90.03	09003	IV THERAPY	0	8,317,896	8,317,896	0.381810	0.000000	90.03
90.04	09004	OP PSYCH	0	258,008	258,008	2.236144	0.000000	90.04
91.00	09100	EMERGENCY	474,191	19,749,819	20,224,010	0.258264	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	70,653	1,836,245	1,906,898	1.432684	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	24,219,962	138,611,806	162,831,768			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,219,962	138,611,806	162,831,768			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.219088	50.00
51.00	05100	RECOVERY ROOM	0.523370	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.680653	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153019	54.00
60.00	06000	LABORATORY	0.252394	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.667183	65.00
65.01	06501	SLEEP LAB	0.300334	65.01
66.00	06600	PHYSICAL THERAPY	0.580455	66.00
69.00	06900	ELECTROCARDIOLOGY	0.201663	69.00
69.01	06901	CARDIAC REHAB	0.494983	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.656662	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761605	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332941	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	76.00
76.01	03480	ONCOLOGY	0.193329	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC - FPC	1.886775	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0.885758	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	1.503018	88.02
90.00	09000	CLINIC	0.667711	90.00
90.01	09001	CLINIC- ORTHO	2.193903	90.01
90.02	09002	CLINIC - PEDS & ENT	1.550312	90.02
90.03	09003	IV THERAPY	0.381810	90.03
90.04	09004	OP PSYCH	2.236144	90.04
91.00	09100	EMERGENCY	0.258264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.432684	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part II | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,801,373	770,606	3,030,767	0	0	50.00
51.00	05100	RECOVERY ROOM	2,208,947	487,386	1,721,561	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,185,189	243,385	941,804	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,164,516	614,367	4,550,149	0	0	54.00
60.00	06000	LABORATORY	4,969,086	293,458	4,675,628	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,614,890	72,990	1,541,900	0	0	65.00
65.01	06501	SLEEP LAB	316,417	81,828	234,589	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,406,792	431,157	1,975,635	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	428,392	30,482	397,910	0	0	69.00
69.01	06901	CARDIAC REHAB	183,668	39,553	144,115	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,916,394	78,704	1,837,690	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,778,978	73,058	1,705,920	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,318,931	101,823	2,217,108	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	3,236,574	729,457	2,507,117	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	2,342,373	230,630	2,111,743	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	2,463,297	193,434	2,269,863	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	1,534,004	109,757	1,424,247	0	0	88.02
90.00	09000	CLINIC	377,339	25,342	351,997	0	0	90.00
90.01	09001	CLINIC- ORTHO	820,759	131,410	689,349	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	1,779,153	206,575	1,572,578	0	0	90.02
90.03	09003	IV THERAPY	3,175,856	68,402	3,107,454	0	0	90.03
90.04	09004	OP PSYCH	576,943	62,083	514,860	0	0	90.04
91.00	09100	EMERGENCY	5,223,130	687,365	4,535,765	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,731,983	421,824	2,310,159	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	52,554,984	6,185,076	46,369,908	0	0	200.00
201.00		Less Observation Beds	2,731,983	421,824	2,310,159	0	0	201.00
202.00		Total (line 200 minus line 201)	49,823,001	5,763,252	44,059,749	0	0	202.00

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

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part II | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,801,373	17,350,898	0.219088	50.00
51.00	05100	RECOVERY ROOM	2,208,947	4,220,625	0.523370	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,185,189	1,741,252	0.680653	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,164,516	33,750,718	0.153019	54.00
60.00	06000	LABORATORY	4,969,086	19,687,821	0.252394	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,614,890	2,420,460	0.667183	65.00
65.01	06501	SLEEP LAB	316,417	1,053,550	0.300334	65.01
66.00	06600	PHYSICAL THERAPY	2,406,792	4,146,389	0.580455	66.00
69.00	06900	ELECTROCARDIOLOGY	428,392	2,124,293	0.201663	69.00
69.01	06901	CARDIAC REHAB	183,668	371,059	0.494983	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,916,394	2,918,389	0.656662	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,778,978	2,335,828	0.761605	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,318,931	6,964,991	0.332941	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	3,236,574	16,741,255	0.193329	76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC - FPC	2,342,373	1,241,469	1.886775	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	2,463,297	2,781,006	0.885758	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	1,534,004	1,020,616	1.503018	88.02
90.00	09000	CLINIC	377,339	565,123	0.667711	90.00
90.01	09001	CLINIC- ORTHO	820,759	374,109	2.193903	90.01
90.02	09002	CLINIC - PEDS & ENT	1,779,153	1,147,610	1.550312	90.02
90.03	09003	IV THERAPY	3,175,856	8,317,896	0.381810	90.03
90.04	09004	OP PSYCH	576,943	258,008	2.236144	90.04
91.00	09100	EMERGENCY	5,223,130	20,224,010	0.258264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,731,983	1,906,898	1.432684	92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	0	0	0.000000	116.00
200.00		Subtotal (sum of lines 50 thru 199)	52,554,984	153,664,273		200.00
201.00		Less Observation Beds	2,731,983	0		201.00
202.00		Total (line 200 minus line 201)	49,823,001	153,664,273		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part II Date/Time Prepared: 4/21/2021 9:44 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	770,606	17,350,898	0.044413	660,548	29,337	50.00
51.00	05100	RECOVERY ROOM	487,386	4,220,625	0.115477	129,535	14,958	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	243,385	1,741,252	0.139776	11,081	1,549	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	614,367	33,750,718	0.018203	501,745	9,133	54.00
60.00	06000	LABORATORY	293,458	19,687,821	0.014906	584,530	8,713	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	72,990	2,420,460	0.030155	394,365	11,892	65.00
65.01	06501	SLEEP LAB	81,828	1,053,550	0.077669	0	0	65.01
66.00	06600	PHYSICAL THERAPY	431,157	4,146,389	0.103984	149,105	15,505	66.00
69.00	06900	ELECTROCARDIOLOGY	30,482	2,124,293	0.014349	205,343	2,946	69.00
69.01	06901	CARDIAC REHAB	39,553	371,059	0.106595	210	22	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,704	2,918,389	0.026968	305,384	8,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,058	2,335,828	0.031277	236,720	7,404	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,823	6,964,991	0.014619	415,164	6,069	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	729,457	16,741,255	0.043572	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	230,630	1,241,469	0.185772	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	193,434	2,781,006	0.069555	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	109,757	1,020,616	0.107540	0	0	88.02
90.00	09000	CLINIC	25,342	565,123	0.044843	0	0	90.00
90.01	09001	CLINIC- ORTHO	131,410	374,109	0.351261	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	206,575	1,147,610	0.180005	0	0	90.02
90.03	09003	IV THERAPY	68,402	8,317,896	0.008223	0	0	90.03
90.04	09004	OP PSYCH	62,083	258,008	0.240624	0	0	90.04
91.00	09100	EMERGENCY	687,365	20,224,010	0.033988	4,963	169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	421,824	1,906,898	0.221210	17,218	3,809	92.00
200.00		Total (lines 50 through 199)	6,185,076	153,664,273		3,615,911	119,742	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/21/2021 9:44 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	0	0	0	0	0	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	0	0	0	0	0	90.04
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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/21/2021 9:44 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	17,350,898	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,220,625	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,741,252	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,750,718	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	19,687,821	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,420,460	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,053,550	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,146,389	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,124,293	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	371,059	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,918,389	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,335,828	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,964,991	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	16,741,255	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	0	0	1,241,469	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	0	0	2,781,006	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	0	0	1,020,616	0.000000	88.02
90.00	09000	CLINIC	0	0	0	565,123	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	374,109	0.000000	90.01
90.02	09002	CLINIC - PEDS & ENT	0	0	0	1,147,610	0.000000	90.02
90.03	09003	IV THERAPY	0	0	0	8,317,896	0.000000	90.03
90.04	09004	OP PSYCH	0	0	0	258,008	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	20,224,010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,906,898	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	153,664,273		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/21/2021 9:44 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	660,548	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	129,535	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	11,081	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	501,745	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	584,530	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	394,365	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	149,105	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	205,343	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	210	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	305,384	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	236,720	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	415,164	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	0.000000	0	0	0	0	90.02
90.03	09003	IV THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	OP PSYCH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	4,963	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	17,218	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,615,911	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part V Date/Time Prepared: 4/21/2021 9:44 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	0.219088	0	3,358,949	0	0	50.00
51.00	05100	RECOVERY ROOM	0.523370	0	592,346	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.680653	0	2,948	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153019	0	7,158,928	0	0	54.00
60.00	06000	LABORATORY	0.252394	0	3,767,660	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.667183	0	204,652	0	0	65.00
65.01	06501	SLEEP LAB	0.300334	0	173,456	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.580455	0	1,090,375	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.201663	0	470,170	0	0	69.00
69.01	06901	CARDIAC REHAB	0.494983	0	114,145	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.656662	0	451,348	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761605	0	451,645	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332941	0	956,234	3,017	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.193329	0	5,880,282	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC						88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE						88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN						88.02
90.00	09000	CLINIC	0.667711	0	241,651	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.193903	0	56,975	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	1.550312	0	50,185	0	0	90.02
90.03	09003	IV THERAPY	0.381810	0	4,511,960	17,825	0	90.03
90.04	09004	OP PSYCH	2.236144	0	22,494	0	0	90.04
91.00	09100	EMERGENCY	0.258264	0	3,490,681	4,230	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.432684	0	1,042,993	0	0	92.00
200.00		Subtotal (see instructions)		0	34,090,077	25,072	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	34,090,077	25,072	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part V Date/Time Prepared: 4/21/2021 9:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	735,905	0	50.00
51.00	05100	RECOVERY ROOM	310,016	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,007	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,095,452	0	54.00
60.00	06000	LABORATORY	950,935	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	136,540	0	65.00
65.01	06501	SLEEP LAB	52,095	0	65.01
66.00	06600	PHYSICAL THERAPY	632,914	0	66.00
69.00	06900	ELECTROCARDIOLOGY	94,816	0	69.00
69.01	06901	CARDIAC REHAB	56,500	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	296,383	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	343,975	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,370	1,004	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	76.00
76.01	03480	ONCOLOGY	1,136,829	0	76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - FPC			88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE			88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN			88.02
90.00	09000	CLINIC	161,353	0	90.00
90.01	09001	CLINIC- ORTHO	124,998	0	90.01
90.02	09002	CLINIC - PEDS & ENT	77,802	0	90.02
90.03	09003	IV THERAPY	1,722,711	6,806	90.03
90.04	09004	OP PSYCH	50,300	0	90.04
91.00	09100	EMERGENCY	901,517	1,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,494,279	0	92.00
200.00		Subtotal (see instructions)	10,695,697	8,902	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	10,695,697	8,902	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part I Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,499,690	133,447	1,366,243	4,013	340.45	30.00
31.00	INTENSIVE CARE UNIT	93,927		93,927	153	613.90	31.00
43.00	NURSERY	33,813		33,813	448	75.48	43.00
200.00	Total (lines 30 through 199)	1,627,430		1,493,983	4,614		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	70	23,832	30.00
31.00	INTENSIVE CARE UNIT	8	4,911	31.00
43.00	NURSERY	52	3,925	43.00
200.00	Total (lines 30 through 199)	130	32,668	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part II | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	770,606	17,350,898	0.044413	115,496	5,130	50.00
51.00	05100	RECOVERY ROOM	487,386	4,220,625	0.115477	18,152	2,096	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	243,385	1,741,252	0.139776	161,010	22,505	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	614,367	33,750,718	0.018203	55,740	1,015	54.00
60.00	06000	LABORATORY	293,458	19,687,821	0.014906	58,613	874	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	72,990	2,420,460	0.030155	7,855	237	65.00
65.01	06501	SLEEP LAB	81,828	1,053,550	0.077669	0	0	65.01
66.00	06600	PHYSICAL THERAPY	431,157	4,146,389	0.103984	3,152	328	66.00
69.00	06900	ELECTROCARDIOLOGY	30,482	2,124,293	0.014349	1,795	26	69.00
69.01	06901	CARDIAC REHAB	39,553	371,059	0.106595	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,704	2,918,389	0.026968	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,058	2,335,828	0.031277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,823	6,964,991	0.014619	48,981	716	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	729,457	16,741,255	0.043572	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	230,630	1,241,469	0.185772	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	193,434	2,781,006	0.069555	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	109,757	1,020,616	0.107540	0	0	88.02
90.00	09000	CLINIC	25,342	565,123	0.044843	0	0	90.00
90.01	09001	CLINIC- ORTHO	131,410	374,109	0.351261	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	206,575	1,147,610	0.180005	0	0	90.02
90.03	09003	IV THERAPY	68,402	8,317,896	0.008223	0	0	90.03
90.04	09004	OP PSYCH	62,083	258,008	0.240624	0	0	90.04
91.00	09100	EMERGENCY	687,365	20,224,010	0.033988	24,924	847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	421,824	1,906,898	0.221210	0	0	92.00
200.00		Total (lines 50 through 199)	6,185,076	153,664,273		495,718	33,774	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part III Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,013	0.00	70	30.00
31.00	03100	INTENSIVE CARE UNIT		0	153	0.00	8	31.00
43.00	04300	NURSERY		0	448	0.00	52	43.00
200.00		Total (lines 30 through 199)		0	4,614		130	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	0	0	0	0	0	90.02
90.03	09003	IV THERAPY	0	0	0	0	0	90.03
90.04	09004	OP PSYCH	0	0	0	0	0	90.04
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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	17,350,898	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,220,625	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,741,252	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,750,718	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	19,687,821	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,420,460	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,053,550	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	4,146,389	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,124,293	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	371,059	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,918,389	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,335,828	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,964,991	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	16,741,255	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0	0	0	1,241,469	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0	0	0	2,781,006	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0	0	0	1,020,616	0.000000	88.02
90.00	09000	CLINIC	0	0	0	565,123	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	374,109	0.000000	90.01
90.02	09002	CLINIC - PEDS & ENT	0	0	0	1,147,610	0.000000	90.02
90.03	09003	IV THERAPY	0	0	0	8,317,896	0.000000	90.03
90.04	09004	OP PSYCH	0	0	0	258,008	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	20,224,010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,906,898	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	153,664,273		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		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	115,496	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	18,152	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	161,010	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	55,740	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	58,613	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	7,855	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	3,152	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,795	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	48,981	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - FPC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	0.000000	0	0	0	0	90.02
90.03	09003	IV THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	OP PSYCH	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	24,924	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)		495,718	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/21/2021 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,742	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,013	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,774	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	93	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)	278	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	90	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)	268	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	835	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)	93	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)	278	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,712,902	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)	11,623	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)	34,610	25.00
26.00	Total swing-bed cost (see instructions)	864,284	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,848,618	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)	8,848,618	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)	2,204.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,841,167	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)	1,841,167	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/21/2021 9:44 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	390,946	153	2,555.20	43	109,874	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)	1,380,537	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,331,578	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)	205,064	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	612,987	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	818,051	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)	1,239	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,204.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,731,983	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/21/2021 9:44 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	1,499,690	9,712,902	0.154402	2,731,983	421,824	90.00
91.00	Nursing School cost	0	9,712,902	0.000000	2,731,983	0	91.00
92.00	Allied health cost	0	9,712,902	0.000000	2,731,983	0	92.00
93.00	All other Medical Education	0	9,712,902	0.000000	2,731,983	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

	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)	4,742	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,013	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,774	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	93	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)	278	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	90	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)	268	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	70	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)	448	15.00
16.00	Nursery days (title V or XIX only)	52	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,712,902	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)	11,623	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)	34,610	25.00
26.00	Total swing-bed cost (see instructions)	864,284	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,848,618	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)	8,848,618	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)	2,204.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	154,349	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)	154,349	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	253,378	448	565.58	52	29,410	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	390,946	153	2,555.20	8	20,442	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)	197,897	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	402,098	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)	32,668	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	33,774	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	66,442	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	335,656	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)	1,239	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,204.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,731,983	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/21/2021 9:44 am
	Title XIX	Hospital	PPS

	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	1,499,690	9,712,902	0.154402	2,731,983	421,824	90.00
91.00	Nursing School cost	0	9,712,902	0.000000	2,731,983	0	91.00
92.00	Allied health cost	0	9,712,902	0.000000	2,731,983	0	92.00
93.00	All other Medical Education	0	9,712,902	0.000000	2,731,983	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 4/21/2021 9:44 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		1,325,091		30.00
31.00	03100	INTENSIVE CARE UNIT		107,500		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.219088	660,548	144,718	50.00
51.00	05100	RECOVERY ROOM	0.523370	129,535	67,795	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.680653	11,081	7,542	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153019	501,745	76,777	54.00
60.00	06000	LABORATORY	0.252394	584,530	147,532	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.667183	394,365	263,114	65.00
65.01	06501	SLEEP LAB	0.300334	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.580455	149,105	86,549	66.00
69.00	06900	ELECTROCARDIOLOGY	0.201663	205,343	41,410	69.00
69.01	06901	CARDIAC REHAB	0.494983	210	104	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.656662	305,384	200,534	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761605	236,720	180,287	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332941	415,164	138,225	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.193329	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - FPC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0.000000		0	88.02
90.00	09000	CLINIC	0.667711	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.193903	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	1.550312	0	0	90.02
90.03	09003	IV THERAPY	0.381810	0	0	90.03
90.04	09004	OP PSYCH	2.236144	0	0	90.04
91.00	09100	EMERGENCY	0.258264	4,963	1,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.432684	17,218	24,668	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,615,911	1,380,537	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)		3,615,911		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 4/21/2021 9:44 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		3,188		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.219088	2,593	568	50.00
51.00	05100	RECOVERY ROOM	0.523370	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.680653	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153019	30,698	4,697	54.00
60.00	06000	LABORATORY	0.252394	62,137	15,683	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.667183	72,575	48,421	65.00
65.01	06501	SLEEP LAB	0.300334	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.580455	182,584	105,982	66.00
69.00	06900	ELECTROCARDIOLOGY	0.201663	23,538	4,747	69.00
69.01	06901	CARDIAC REHAB	0.494983	839	415	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.656662	33,569	22,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761605	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332941	93,203	31,031	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.193329	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - FPC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	0.000000		0	88.02
90.00	09000	CLINIC	0.667711	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.193903	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	1.550312	0	0	90.02
90.03	09003	IV THERAPY	0.381810	0	0	90.03
90.04	09004	OP PSYCH	2.236144	0	0	90.04
91.00	09100	EMERGENCY	0.258264	300	77	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.432684	2,949	4,225	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		504,985	237,889	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)		504,985		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		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		94,103		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.219088	115,496	25,304	50.00
51.00	05100	RECOVERY ROOM	0.523370	18,152	9,500	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.680653	161,010	109,592	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153019	55,740	8,529	54.00
60.00	06000	LABORATORY	0.252394	58,613	14,794	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.667183	7,855	5,241	65.00
65.01	06501	SLEEP LAB	0.300334	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.580455	3,152	1,830	66.00
69.00	06900	ELECTROCARDIOLOGY	0.201663	1,795	362	69.00
69.01	06901	CARDIAC REHAB	0.494983	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.656662	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.761605	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.332941	48,981	16,308	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.193329	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - FPC	1.886775	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - URGENT CARE	0.885758	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC - OB/GYN	1.503018	0	0	88.02
90.00	09000	CLINIC	0.667711	0	0	90.00
90.01	09001	CLINIC- ORTHO	2.193903	0	0	90.01
90.02	09002	CLINIC - PEDS & ENT	1.550312	0	0	90.02
90.03	09003	IV THERAPY	0.381810	0	0	90.03
90.04	09004	OP PSYCH	2.236144	0	0	90.04
91.00	09100	EMERGENCY	0.258264	24,924	6,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.432684	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		495,718	197,897	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)		495,718		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E Part B | Date/Time Prepared: 4/21/2021 9:44 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,704,599	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	10,704,599	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	10,811,645	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)	79,593	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,038,895	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,693,157	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,693,157	30.00
31.00	Primary payer payments	6,468	31.00
32.00	Subtotal (line 30 minus line 31)	4,686,689	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)	826,325	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	537,111	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	487,698	36.00
37.00	Subtotal (see instructions)	5,223,800	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)	5,223,800	40.00
40.01	Sequestration adjustment (see instructions)	60,596	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	5,844,024	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)	-680,820	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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-1 Part I Date/Time Prepared: 4/21/2021 9:44 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		2,557,225		5,844,024	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	04/29/2020	110,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		110,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,667,225		5,844,024	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		399,149		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		680,820	6.02
7.00	Total Medicare program liability (see instructions)		3,066,374		5,163,204	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: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 4/21/2021 9:44 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		858,545		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	04/29/2020	38,900		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)		38,900		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)		897,445		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		151,508		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,048,953		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: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/21/2021 9:44 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: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-2 | Date/Time Prepared: 4/21/2021 9:44 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)	826,232	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)	240,268	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	371	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,066,500	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,066,500	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,066,500	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,236	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,061,264	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,061,264	0	19.00
19.01	Sequestration adjustment (see instructions)	12,311	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	897,445	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)	151,508	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: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 4/21/2021 9:44 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,331,578	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)	3,331,578	4.00
5.00	Primary payer payments	10,056	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,354,838	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)	3,354,838	19.00
20.00	Deductibles (exclude professional component)	276,012	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,078,826	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,078,826	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	36,207	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	23,535	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,891	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,102,361	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,102,361	30.00
30.01	Sequestration adjustment (see instructions)	35,987	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,667,225	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)	399,149	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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-3 Part VII Date/Time Prepared: 4/21/2021 9:44 am

Title XIX | Hospital | PPS

		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	0		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)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	94,103		8.00
9.00	Ancillary service charges	495,718	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)	589,821	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)	589,821	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	589,821	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)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	298,360	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)	298,360	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)	298,360	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)	298,360	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	6,213	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)	292,147	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	292,147	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)	292,147	0	40.00
41.00	Interim payments	292,147	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G | Date/Time Prepared: 4/21/2021 9:44 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	19,298,493	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	8,511,128	0	0	0	4.00
5.00	Other receivable	785,247	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,395,002	0	0	0	7.00
8.00	Prepaid expenses	736,753	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)	30,726,623	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,419,367	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	57,618,245	0	0	0	15.00
16.00	Accumulated depreciation	-24,594,174	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	20,351,820	0	0	0	23.00
24.00	Accumulated depreciation	-16,676,039	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,119,219	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	25,804,843	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	933,114	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,737,957	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	95,583,799	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,022,075	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,501,635	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	8,713,784	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	654,980	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,892,474	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	45,392,510	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	45,392,510	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	60,284,984	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	35,298,815				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	35,298,815	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	95,583,799	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-1 | Date/Time Prepared: 4/21/2021 9:44 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		34,890,275		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		408,540				2.00
3.00	Total (sum of line 1 and line 2)		35,298,815		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)		35,298,815		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)		35,298,815		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: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 4/21/2021 9:44 am

	Cost Center Description	Inpatient 1.00	Outpatient 2.00	Total 3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,787,495		8,787,495	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,787,495		8,787,495	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	380,000		380,000	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)	380,000		380,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,167,495		9,167,495	17.00
18.00	Ancillary services	14,488,341	101,339,192	115,827,533	18.00
19.00	Outpatient services	547,728	32,245,927	32,793,655	19.00
20.00	RURAL HEALTH CLINIC - FPC	16,401	1,225,068	1,241,469	20.00
20.01	RURAL HEALTH CLINIC - URGENT CARE	0	2,781,006	2,781,006	20.01
20.02	RURAL HEALTH CLINIC - OB/GYN	0	1,020,616	1,020,616	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	HOSPITALIST FEES	0	0	0	27.00
27.01	OTHER REVENUE	558,365	1,968,414	2,526,779	27.01
27.02	PROFESSIONAL FEES	190,299	1,517,258	1,707,557	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,968,629	142,097,481	167,066,110	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		73,183,497		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)		73,183,497		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet G-3 Date/Time Prepared: 4/21/2021 9:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	167,066,110	1.00
2.00	Less contractual allowances and discounts on patients' accounts	98,807,361	2.00
3.00	Net patient revenues (line 1 minus line 2)	68,258,749	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	73,183,497	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,924,748	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	189,250	6.00
7.00	Income from investments	2,083,369	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 INCOME	825,774	24.00
24.01	OTHER (SPECIFY)	0	24.01
24.02	GAIN/LOSS ON DISPOSAL OF ASSETS	-104,821	24.02
24.50	COVID-19 PHE Funding	2,339,716	24.50
25.00	Total other income (sum of lines 6-24)	5,333,288	25.00
26.00	Total (line 5 plus line 25)	408,540	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)	408,540	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/21/2021 9:44 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	411,175	9,348	420,523	-4,441	416,082	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	233,563	0	233,563	-2,522	231,041	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	278,009	0	278,009	0	278,009	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	16,109	0	16,109	-174	15,935	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)	938,856	9,348	948,204	-7,137	941,067	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	4,737	4,737	0	4,737	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	4,737	4,737	0	4,737	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	938,856	14,085	952,941	-7,137	945,804	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	7,163	7,163	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	7,163	7,163	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	657	657	0	657	29.00
30.00	Administrative Costs	97,182	63,155	160,337	-26	160,311	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	97,182	63,812	160,994	-26	160,968	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,036,038	77,897	1,113,935	0	1,113,935	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2019 To 09/30/2020	Worksheet M-1 Date/Time Prepared: 4/21/2021 9:44 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	416,082	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	231,041	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	278,009	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	15,935	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	941,067	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	4,737	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	4,737	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	945,804	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	7,163	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	7,163	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	657	29.00
30.00	Administrative Costs	0	160,311	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	160,968	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,113,935	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/21/2021 9:44 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	369,645	0	369,645	0	369,645	1.00
2.00	Physician Assistant	116,073	0	116,073	0	116,073	2.00
3.00	Nurse Practitioner	242,282	0	242,282	0	242,282	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	144,473	0	144,473	0	144,473	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	7,553	0	7,553	0	7,553	9.00
10.00	Subtotal (sum of lines 1 through 9)	880,026	0	880,026	0	880,026	10.00
11.00	Physician Services Under Agreement	0	44,654	44,654	0	44,654	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	44,654	44,654	0	44,654	14.00
15.00	Medical Supplies	0	124,643	124,643	0	124,643	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	124,643	124,643	0	124,643	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	880,026	169,297	1,049,323	0	1,049,323	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	1,202	1,202	0	1,202	29.00
30.00	Administrative Costs	304,745	15,957	320,702	-28,529	292,173	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	304,745	17,159	321,904	-28,529	293,375	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,184,771	186,456	1,371,227	-28,529	1,342,698	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1

Component CCN: 15-8545 | Date/Time Prepared: 4/21/2021 9:44 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	369,645	1.00
2.00	Physician Assistant	0	116,073	2.00
3.00	Nurse Practitioner	0	242,282	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	144,473	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	7,553	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	880,026	10.00
11.00	Physician Services Under Agreement	0	44,654	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	44,654	14.00
15.00	Medical Supplies	0	124,643	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	124,643	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,049,323	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	1,202	29.00
30.00	Administrative Costs	0	292,173	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	293,375	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,342,698	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1

Component CCN: 15-8546 | Date/Time Prepared: 4/21/2021 9:44 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	740,505	0	740,505	-111,278	629,227	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	169,894	0	169,894	-25,532	144,362	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	208,122	0	208,122	-31,275	176,847	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)	1,118,521	0	1,118,521	-168,085	950,436	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	2,932	2,932	0	2,932	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	2,932	2,932	0	2,932	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,118,521	2,932	1,121,453	-168,085	953,368	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	45,763	64,825	110,588	-17,059	93,529	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	45,763	64,825	110,588	-17,059	93,529	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,164,284	67,757	1,232,041	-185,144	1,046,897	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/21/2021 9:44 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	-259,639	369,588	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-45,975	98,387	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	176,847	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)	-305,614	644,822	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	2,932	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	2,932	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-305,614	647,754	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	0	93,529	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,529	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-305,614	741,283	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2019 To 09/30/2020	Worksheet M-2 Date/Time Prepared: 4/21/2021 9:44 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	0.70	3,396	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.67	5,157	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.37	8,553		3	8,553	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	0.08	63			63	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)	2.45	8,616			8,616	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)	945,804	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	7,163	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	952,967	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.992483	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	160,968	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,228,438	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,389,406	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,389,406	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,378,962	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,324,766	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1315 Component CCN: 15-8545	Period: From 10/01/2019 To 09/30/2020	Worksheet M-2 Date/Time Prepared: 4/21/2021 9:44 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	1.00	2,094	1	1		1.00
2.00	Physician Assistant	0.68	3,537	1	1		2.00
3.00	Nurse Practitioner	1.72	7,347	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.40	12,978		4	12,978	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)	3.40	12,978			12,978	8.00
9.00	Physician Services Under Agreements		552			552	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)	1,049,323	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)	1,049,323	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)	293,375	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,120,599	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,413,974	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,413,974	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,413,974	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,463,297	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-2 | Date/Time Prepared: 4/21/2021 9:44 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.75	1,732	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.63	1,562	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.38	3,294		2	3,294	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.38	3,294			3,294	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)	647,754	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)	647,754	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)	93,529	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	792,721	15.00
16.00	Total overhead (sum of lines 14 and 15)	886,250	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	886,250	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	886,250	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,534,004	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-3 | Date/Time Prepared: 4/21/2021 9:44 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)		2,324,766	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		33,710	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,291,056	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,616	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)		8,616	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		265.91	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	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	265.91	265.91	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,419	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	377,326	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	2	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	532	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	532	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	377,858	16.00
16.01	Total program charges (see instructions)(from contractor's records)		180,805	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,268	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,009	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.)		269,848	16.04
16.05	Total program cost (see instructions)	0	280,857	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		29,539	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		29,198	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		280,857	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		21,074	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		301,931	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)		301,931	26.00
26.01	Sequestration adjustment (see instructions)		3,502	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		263,581	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)		34,848	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: 15-1315 Component CCN: 15-8545	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/21/2021 9:44 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)		2,463,297	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,463,297	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		12,978	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		552	5.00
6.00	Total adjusted visits (line 4 plus line 5)		13,530	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		182.06	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	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	182.06	182.06	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	384	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	69,911	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	69,911	16.00
16.01	Total program charges (see instructions)(from contractor's records)		67,456	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.)		55,929	16.04
16.05	Total program cost (see instructions)	0	55,929	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,046	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		55,929	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		55,929	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)		55,929	26.00
26.01	Sequestration adjustment (see instructions)		649	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		42,614	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)		12,666	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: 15-1315 Component CCN: 15-8546	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/21/2021 9:44 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)		1,534,004	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		4,535	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,529,469	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,294	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)		3,294	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		464.32	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	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	464.32	464.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	63	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	29,252	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	29,252	16.00
16.01	Total program charges (see instructions)(from contractor's records)		12,271	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		712	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,697	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.)		21,342	16.04
16.05	Total program cost (see instructions)	0	23,039	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		878	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,136	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		23,039	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		245	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		23,284	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)		23,284	26.00
26.01	Sequestration adjustment (see instructions)		270	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		14,512	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)		8,502	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: 15-1315 Component CCN: 15-8530	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/21/2021 9:44 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)	941,067	941,067	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000354	0.004358	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	333	4,101	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,597	4,684	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,930	8,785	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	945,804	945,804	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,378,962	1,378,962	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005212	0.009288	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,187	12,808	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	12,117	21,593	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	23	283	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	526.83	76.30	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	19	145	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	10,010	11,064	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)		33,710	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)		21,074	16.00

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

Provider CCN: 15-1315
Component CCN: 15-8546
Period: From 10/01/2019 To 09/30/2020
Worksheet M-4
Date/Time Prepared: 4/21/2021 9:44 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)	644,822	644,822	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.002021	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	1,303	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	612	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	1,915	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	647,754	647,754	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	886,250	886,250	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.002956	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	2,620	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	4,535	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	37	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	122.57	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	2	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	245	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)		4,535	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)		245	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/21/2021 9:44 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		234,281	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		04/29/2020	29,300	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)		29,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		263,581	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		34,848	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		298,429	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: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-5 | Date/Time Prepared: 4/21/2021 9:44 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		42,614	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)		42,614	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		12,666	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		55,280	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: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-5 | Date/Time Prepared: 4/21/2021 9:44 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		14,512	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)		14,512	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		8,502	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		23,014	7.00

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