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: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 6/22/2021 8:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/22/2021 Time: 8:27 pm
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 DECATUR CO. MEMORIAL HOSPITAL (15-1332) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
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	806,719	1,186,594	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	82,611	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 I	0		540,333		0	10.00
10.01	RURAL HEALTH CLINIC II	0		268,843		0	10.01
200.00	Total	0	889,330	1,995,770	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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/22/2021 8:27 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 720 NORTH LINCOLN STREET	PO Box:			1.00
2.00	City: GREENSBURG	State: IN	Zip Code: 47240-1398	County: DECATUR	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	DECATUR CO. MEMORIAL HOSPITAL	151332	99915	1	12/01/2005	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	DECATUR CO. SWING BED	15Z332	99915		12/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	TREE CITY MEDICAL PARTNERS	158522	99915		05/04/2017	N	N	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	DECATUR COUNTY PRIMARY CARE	158521	99915		05/04/2017	N	N	N	15.01
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)	01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/22/2021 8:27 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/22/2021 8:27 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/22/2021 8:27 pm

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/22/2021 8:27 pm

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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.	N	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.	N	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.	N	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.	N	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

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				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	Y	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	394,337	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/22/2021 8:27 pm

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

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

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

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

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

		Part A	Part B	Title V	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)		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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/22/2021 8:27 pm

		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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 6/22/2021 8:27 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/31/2021	Y	03/31/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 6/22/2021 8:27 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173834000	KBEJARANO@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 6/22/2021 8:27 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/22/2021 8:27 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	74,448.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	74,448.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	74,448.00	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						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/22/2021 8:27 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,513	135	3,102			1.00
2.00	HMO and other (see instructions)	0	307				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	246	0	285			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	36			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,759	135	3,423			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		239	393			13.00
14.00	Total (see instructions)	1,759	374	3,816	0.00	321.74	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						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,388	2,359	17,533	0.00	34.77	26.00
26.01	RURAL HEALTH CLINIC II	4,171	3,447	17,186	0.00	25.09	26.01
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	381.60	27.00
28.00	Observation Bed Days		0	662			28.00
29.00	Ambulance Trips	1,160					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	92			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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/22/2021 8:27 pm

	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	420	289	1,536	1.00
2.00	HMO and other (see instructions)			0	0		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	420	289	1,536	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						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	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: 15-1332 | Component CCN: 15-8522 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 6/22/2021 8:27 pm

RHC I

				1.00		
	Clinic Address and Identification					
1.00	Street			955 N MICHIGAN AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GREENSBURG		IN	47240	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	12:00	08:00	07:00	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		DECATUR				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	07:00	08:00	07:00	08:00	07:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1332
Component CCN: 15-8522

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

Worksheet S-8

Date/Time Prepared:
6/22/2021 8:27 pm

RHC I

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	07:00	09:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1332 | Component CCN: 15-8521 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 6/22/2021 8:27 pm

RHC II

				1.00		
	Clinic Address and Identification					
1.00	Street			718 N LINCOLN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GREENSBURG		IN	47240	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			07:30	05:00	07:30	11.00

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

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

		Y/N	V	XVIII	XIX	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		DECATUR				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	05:00	07:30	05:00	07:30	05:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1332
Component CCN: 15-8521

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

Worksheet S-8

Date/Time Prepared:
6/22/2021 8:27 pm

RHC II

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 6/22/2021 8:27 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.439837	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,203,726	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,347,861	5.00
6.00	Medicaid charges	27,342,520	6.00
7.00	Medicaid cost (line 1 times line 6)	12,026,252	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	6,474,665	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,474,665	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,745,423	0	1,745,423	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	767,702	0	767,702	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)	767,702	0	767,702	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)	5,001,477	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	402,104	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	618,621	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,382,856	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,144,259	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,911,961	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,386,626	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 6/22/2021 8:27 pm

		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		3,934,252	3,934,252	0	3,934,252	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	206,087	7,886,384	8,092,471	0	8,092,471	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,908,173	8,685,916	13,594,089	-287,892	13,306,197	5.00
6.00	00600	MAINTENANCE & REPAIRS	384,805	960,926	1,345,731	0	1,345,731	6.00
7.00	00700	OPERATION OF PLANT	0	952,412	952,412	0	952,412	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	62,572	43,252	105,824	0	105,824	8.00
9.00	00900	HOUSEKEEPING	340,172	261,681	601,853	0	601,853	9.00
10.00	01000	DIETARY	228,055	637,033	865,088	-673,357	191,731	10.00
11.00	01100	CAFETERIA	0	0	0	673,357	673,357	11.00
13.00	01300	NURSING ADMINISTRATION	625,936	13,275	639,211	0	639,211	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,298	18,154	76,452	0	76,452	14.00
15.00	01500	PHARMACY	852,949	229,849	1,082,798	0	1,082,798	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	459,846	149,571	609,417	0	609,417	16.00
17.00	01700	SOCIAL SERVICE	288,618	12,270	300,888	0	300,888	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,435,089	171,375	3,606,464	-211,345	3,395,119	30.00
43.00	04300	NURSERY	0	0	0	135,495	135,495	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,245,569	623,123	1,868,692	0	1,868,692	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	75,850	75,850	52.00
53.00	05300	ANESTHESIOLOGY	705,476	586,711	1,292,187	59,684	1,351,871	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,346,036	1,792,266	3,138,302	-150,429	2,987,873	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	52,800	52,800	150,429	203,229	55.01
60.00	06000	LABORATORY	370,708	3,431,493	3,802,201	0	3,802,201	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	94,793	94,793	0	94,793	62.00
65.00	06500	RESPIRATORY THERAPY	709,625	205,582	915,207	-86,648	828,559	65.00
66.00	06600	PHYSICAL THERAPY	847,181	15,354	862,535	0	862,535	66.00
67.00	06700	OCCUPATIONAL THERAPY	275,614	4,438	280,052	0	280,052	67.00
68.00	06800	SPEECH PATHOLOGY	146,428	32,675	179,103	0	179,103	68.00
69.00	06900	ELECTROCARDIOLOGY	144,311	29,962	174,273	86,648	260,921	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,423,314	2,423,314	-801,547	1,621,767	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	741,863	741,863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,678,945	7,678,945	0	7,678,945	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,442,777	211,612	2,654,389	285,782	2,940,171	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,346,513	309,326	2,655,839	2,794	2,658,633	88.01
90.00	09000	CLINIC	1,204,607	139,960	1,344,567	0	1,344,567	90.00
90.01	09001	ONCOLOGY	363,451	218,193	581,644	0	581,644	90.01
90.02	09002	OUTPATIENT CLINIC	140,900	4,379	145,279	0	145,279	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1,876	84	1,960	0	1,960	90.05
90.06	09006	CLINIC	472,757	102,715	575,472	0	575,472	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	1,218,958	82,663	1,301,621	0	1,301,621	90.07
90.08	09008	PAIN MANAGEMENT	0	0	0	0	0	90.08
90.09	09009	GERIATRIC PSYCH	35,738	361,758	397,496	0	397,496	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	572,648	7,974	580,622	0	580,622	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	189,845	101	189,946	0	189,946	90.11
90.12	09012	DIABETES CLINIC	4,744	3,366	8,110	0	8,110	90.12
90.13	09013	NEUROLOGY	257,297	371	257,668	0	257,668	90.13
90.14	09014	FOOT AND ANKLE	108,584	5,626	114,210	0	114,210	90.14
91.00	09100	EMERGENCY	1,744,977	1,163,551	2,908,528	0	2,908,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	965,240	100,814	1,066,054	0	1,066,054	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,712,460	43,640,299	73,352,759	684	73,353,443	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	MARKETING	202,368	377,646	580,014	-684	579,330	194.00
194.02	07952	NRCC	0	0	0	0	0	194.02
194.05	07955	RETAIL PHARMACY	404,958	2,611,696	3,016,654	0	3,016,654	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	30,319,786	46,629,641	76,949,427	0	76,949,427	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 6/22/2021 8:27 pm

		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	-78,970	3,855,282		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-906,236	7,186,235		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,108,016	10,198,181		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,345,731		6.00
7.00	00700	OPERATION OF PLANT	0	952,412		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	105,824		8.00
9.00	00900	HOUSEKEEPING	0	601,853		9.00
10.00	01000	DIETARY	-142,390	49,341		10.00
11.00	01100	CAFETERIA	0	673,357		11.00
13.00	01300	NURSING ADMINISTRATION	-950	638,261		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-27,861	48,591		14.00
15.00	01500	PHARMACY	0	1,082,798		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	609,417		16.00
17.00	01700	SOCIAL SERVICE	0	300,888		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-636,510	2,758,609		30.00
43.00	04300	NURSERY	0	135,495		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-96,928	1,771,764		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	75,850		52.00
53.00	05300	ANESTHESIOLOGY	-1,201,767	150,104		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,122,466	1,865,407		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
55.01	03630	ULTRA SOUND	0	203,229		55.01
60.00	06000	LABORATORY	-431,075	3,371,126		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	94,793		62.00
65.00	06500	RESPIRATORY THERAPY	-49,801	778,758		65.00
66.00	06600	PHYSICAL THERAPY	-149,281	713,254		66.00
67.00	06700	OCCUPATIONAL THERAPY	-79,274	200,778		67.00
68.00	06800	SPEECH PATHOLOGY	-9,026	170,077		68.00
69.00	06900	ELECTROCARDIOLOGY	-12,600	248,321		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,621,767		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	741,863		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,597,898	6,081,047		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,940,171		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,658,633		88.01
90.00	09000	CLINIC	-938,877	405,690		90.00
90.01	09001	ONCOLOGY	-191,774	389,870		90.01
90.02	09002	OUTPATIENT CLINIC	-4,923	140,356		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	1,960		90.05
90.06	09006	CLINIC	-246,167	329,305		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	-1,079,657	221,964		90.07
90.08	09008	PAIN MANAGEMENT	183,524	183,524		90.08
90.09	09009	GERIATRIC PSYCH	13,408	410,904		90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	-493,092	87,530		90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	-154,909	35,037		90.11
90.12	09012	DIABETES CLINIC	-1,300	6,810		90.12
90.13	09013	NEUROLOGY	-252,792	4,876		90.13
90.14	09014	FOOT AND ANKLE	-91,031	23,179		90.14
91.00	09100	EMERGENCY	-580,337	2,328,191		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	2,068	1,068,122		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,486,908	59,866,535		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MARKETING	0	579,330		194.00
194.02	07952	NRCC	0	0		194.02
194.05	07955	RETAIL PHARMACY	0	3,016,654		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,486,908	63,462,519		200.00

RECLASSIFICATIONS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/22/2021 8:27 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ULTRASOUND SALARY RECLASS				
1.00	ULTRA SOUND	55.01	150,429	0	1.00
	0		150,429	0	
	B - L&D AND NURSERY RECLASS				
1.00	NURSERY	43.00	127,776	7,719	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	71,529	4,321	2.00
	0		199,305	12,040	
	C - EKG SALARY RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	86,648	0	1.00
	0		86,648	0	
	D - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	177,511	495,846	1.00
	0		177,511	495,846	
	E - ANESTHESIA GAS EXPENSE				
1.00	ANESTHESIOLOGY	53.00	0	59,684	1.00
	0		0	59,684	
	F - MARKETING EXPENSE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	684	1.00
	0		0	684	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	741,863	1.00
	0		0	741,863	
	H - RCH CALL CENTER RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	143,103	1,185	1.00
2.00	RURAL HEALTH CLINIC II	88.01	143,103	1,185	2.00
	0		286,206	2,370	
	I - RHC SALARY RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	141,494	0	1.00
	0		141,494	0	
500.00	Grand Total: Increases		1,041,593	1,312,487	500.00

RECLASSIFICATIONS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/22/2021 8:27 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ULTRASOUND SALARY RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	150,429	0	0		1.00
	0		150,429	0			
	B - L&D AND NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	199,305	12,040	0		1.00
2.00		0.00	0	0	0		2.00
	0		199,305	12,040			
	C - EKG SALARY RECLASS						
1.00	RESPIRATORY THERAPY	65.00	86,648	0	0		1.00
	0		86,648	0			
	D - CAFETERIA RECLASS						
1.00	DIETARY	10.00	177,511	495,846	0		1.00
	0		177,511	495,846			
	E - ANESTHESIA GAS EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	59,684	0		1.00
	0		0	59,684			
	F - MARKETING EXPENSE RECLASS						
1.00	MARKETING	194.00	0	684	0		1.00
	0		0	684			
	G - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	741,863	0		1.00
	0		0	741,863			
	H - RCH CALL CENTER RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	286,206	2,370	0		1.00
2.00		0.00	0	0	0		2.00
	0		286,206	2,370			
	I - RHC SALARY RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	141,494	0	0		1.00
	0		141,494	0			
500.00	Grand Total: Decreases		1,041,593	1,312,487			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 6/22/2021 8:27 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	1,134,637	0	0	0	0	1.00
2.00	Land Improvements	537,869	0	0	0	0	2.00
3.00	Buildings and Fixtures	35,743,871	25,749	0	25,749	0	3.00
4.00	Building Improvements	8,630,651	0	0	0	0	4.00
5.00	Fixed Equipment	2,557,216	0	0	0	0	5.00
6.00	Movable Equipment	18,098,526	739,398	0	739,398	45,927	6.00
7.00	HIT designated Assets	8,174,780	6,761,851	0	6,761,851	0	7.00
8.00	Subtotal (sum of lines 1-7)	74,877,550	7,526,998	0	7,526,998	45,927	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	74,877,550	7,526,998	0	7,526,998	45,927	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,134,637	0	1.00
2.00	Land Improvements	537,869	0	2.00
3.00	Buildings and Fixtures	35,769,620	0	3.00
4.00	Building Improvements	8,630,651	0	4.00
5.00	Fixed Equipment	2,557,216	0	5.00
6.00	Movable Equipment	18,791,997	0	6.00
7.00	HIT designated Assets	14,936,631	0	7.00
8.00	Subtotal (sum of lines 1-7)	82,358,621	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	82,358,621	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 6/22/2021 8:27 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,806,565	0	127,687	0	0	1.00
3.00	Total (sum of lines 1-2)	3,806,565	0	127,687	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	3,934,252		1.00
3.00	Total (sum of lines 1-2)	0	3,934,252		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 6/22/2021 8:27 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	63,566,624	0	63,566,624	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	63,566,624	0	63,566,624	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,855,282	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	3,855,282	0	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	0	0	0	3,855,282	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,855,282	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 6/22/2021 8:27 pm

	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	-127,687	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,967,972			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	328,019			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-925	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - 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	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 6/22/2021 8:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	-9,026	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	PHYSICIAN MALPRACTICE COSTS	B	-394,337	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ADMIN REBATES/DISCOUNTS	B	-84,078	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	ADMIN MISC REVENUE	B	-51,809	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CATERING COSTS	B	-141,465	DIETARY	10.00	0	33.03
33.04	MEDICAL RECORDS MISC REVENUE	B	-27,861	CENTRAL SERVICES & SUPPLY	14.00	0	33.04
33.05	OP CLINIC MISC REVENUE	B	-4,923	OUTPATIENT CLINIC	90.02	0	33.05
33.06	NURSING ADMIN REVENUE	B	-950	NURSING ADMINISTRATION	13.00	0	33.06
33.07	LAB MISC REVENUE	B	19	LABORATORY	60.00	0	33.07
33.08	PT MISC REVENUE	B	-146,710	PHYSICAL THERAPY	66.00	0	33.08
33.09	OT MISC REVENUE	B	-79,274	OCCUPATIONAL THERAPY	67.00	0	33.09
33.10	PHARMACY REBATES/DISCOUNTS	B	-1,370	DRUGS CHARGED TO PATIENTS	73.00	0	33.10
33.11	PHARMACY MISC REVENUE	B	-20,104	DRUGS CHARGED TO PATIENTS	73.00	0	33.11
33.12	RADIOLOGY REVENUE	B	-5,456	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	WOMEN'S CLINIC MISC REVENUE	B	-90	WOMEN'S HEALTH SERVICES	90.07	0	33.13
33.14	PAIN MGMT MISC REVENUE	B	-95,778	PAIN MANAGEMENT	90.08	0	33.14
33.15	DIABETES MISC REVENUE	B	-1,300	DIABETES CLINIC	90.12	0	33.15
33.16	340B COSTS	B	-1,576,424	DRUGS CHARGED TO PATIENTS	73.00	0	33.16
33.17	LEASED SPACE RENTAL INCOME	B	-12,925	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PHYSICIAN RECRUITMENT	A	-85,398	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PATIENT TELEPHONE EXPENSE	A	-13,136	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	PATIENT TELEPHONE BENEFITS	A	-2,344	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	PHYSICIAN BENEFITS	A	-895,124	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22	AHA/IHA LOBBYING EXPENSE	A	-5,456	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	CARDIOPULM MISC REVENUE	B	-247	RESPIRATORY THERAPY	65.00	0	33.23
33.24	CRNA OFFSET	A	-608,361	ANESTHESIOLOGY	53.00	0	33.24
33.25	BILLING COSTS OFFSET	A	-108,340	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	BILLING COSTS OFFSET	A	-8,768	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	HOSPITAL ASSESSMENT FEE	A	-2,328,952	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	ADMIN CONTRIBUTION/DONATION EXP	A	-23,890	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	GEROPSYCH START UP	A	13,408	GERIATRIC PSYCH	90.09	0	33.29
33.30	EMS REVENUE	B	2,068	AMBULANCE SERVICES	95.00	0	33.30
33.31	MEDICAL STAFF CONTRIBUTIONS	B	305	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	CARDIOPALM MISC REVENUE	B	-247	RESPIRATORY THERAPY	65.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,486,908				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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 6/22/2021 8:27 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	48,717	0	1.00
2.00	90.08	PAIN MANAGEMENT	OPERATING EXPENSE	279,302	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			328,019	0	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	G	COUNTY	100.00	COUNTY	100.00	6.00
7.00	C	PAIN MANAGEMENT	51.00	PAIN MANAGEMENT	51.00	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:	COUNTY				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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 6/22/2021 8:27 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	48,717	9		1.00
2.00	279,302	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	328,019			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	COUNTY		6.00
7.00	JOINT VENTURE		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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 6/22/2021 8:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	636,510	636,510	0	0	0	1.00
2.00	50.00	OPERATING ROOM	96,928	96,928	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	593,406	593,406	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	1,117,010	1,117,010	0	0	0	4.00
5.00	60.00	LABORATORY	431,094	431,094	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	49,307	49,307	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	2,571	2,571	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	12,600	12,600	0	0	0	8.00
9.00	90.00	CLINIC	938,877	938,877	0	0	0	9.00
10.00	90.01	ONCOLOGY	191,774	191,774	0	0	0	10.00
11.00	90.06	CLINIC	246,167	246,167	0	0	0	11.00
12.00	90.07	WOMEN'S HEALTH SERVICES	1,079,567	1,079,567	0	0	0	12.00
13.00	90.10	PROVIDER BASED CLINIC - DCPM	493,092	493,092	0	0	0	13.00
14.00	90.11	PROVIDER BASED CLINIC - NEPHROLOGY	154,909	154,909	0	0	0	14.00
15.00	90.13	NEUROLOGY	252,792	252,792	0	0	0	15.00
16.00	90.14	FOOT AND ANKLE	91,031	91,031	0	0	0	16.00
17.00	91.00	EMERGENCY	1,334,870	580,337	754,533	0	0	17.00
200.00			7,722,505	6,967,972	754,533		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	90.01	ONCOLOGY	0	0	0	0	0	10.00
11.00	90.06	CLINIC	0	0	0	0	0	11.00
12.00	90.07	WOMEN'S HEALTH SERVICES	0	0	0	0	0	12.00
13.00	90.10	PROVIDER BASED CLINIC - DCPM	0	0	0	0	0	13.00
14.00	90.11	PROVIDER BASED CLINIC - NEPHROLOGY	0	0	0	0	0	14.00
15.00	90.13	NEUROLOGY	0	0	0	0	0	15.00
16.00	90.14	FOOT AND ANKLE	0	0	0	0	0	16.00
17.00	91.00	EMERGENCY	0	0	0	0	0	17.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	636,510		1.00
2.00	50.00	OPERATING ROOM	0	0	0	96,928		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	593,406		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,117,010		4.00
5.00	60.00	LABORATORY	0	0	0	431,094		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	49,307		6.00
7.00	66.00	PHYSICAL THERAPY	0	0	0	2,571		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	12,600		8.00
9.00	90.00	CLINIC	0	0	0	938,877		9.00
10.00	90.01	ONCOLOGY	0	0	0	191,774		10.00
11.00	90.06	CLINIC	0	0	0	246,167		11.00
12.00	90.07	WOMEN'S HEALTH SERVICES	0	0	0	1,079,567		12.00
13.00	90.10	PROVIDER BASED CLINIC - DCPM	0	0	0	493,092		13.00
14.00	90.11	PROVIDER BASED CLINIC - NEPHROLOGY	0	0	0	154,909		14.00
15.00	90.13	NEUROLOGY	0	0	0	252,792		15.00
16.00	90.14	FOOT AND ANKLE	0	0	0	91,031		16.00
17.00	91.00	EMERGENCY	0	0	0	580,337		17.00
200.00			0	0	0	6,967,972		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/22/2021 8:27 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					2	1.00
2.00	Line 1 multiplied by 15 hours per week					30	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					6	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	47.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	86.81	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.41	43.41	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					4,123	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					4,123	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					4,123	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					4,123	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					260	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					260	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					20	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					280	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					280	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/22/2021 8:27 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	86.81	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	4,123		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	280		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	4,403		63.00
64.00	Total cost of outside supplier services (from your records)	0		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	260		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	20		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	280		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	20		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	20		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/22/2021 8:27 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					18	1.00
2.00	Line 1 multiplied by 15 hours per week					270	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					36	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	250.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.10	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.55	39.55	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					19,775	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					19,775	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					19,775	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					79.10	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					21,357	22.00
23.00	Total salary equivalency (see instructions)					21,357	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					1,424	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,424	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					117	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,541	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,541	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/22/2021 8:27 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.10	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	21,357	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	1,541	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	22,898	63.00
64.00	Total cost of outside supplier services (from your records)	31,924	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	9,026	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,424	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	117	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,541	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	117	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	117	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,855,282	3,855,282				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,186,235	50,060	7,236,295			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,198,181	269,405	1,319,092	11,786,678	11,786,678	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,345,731	415,148	110,900	1,871,779	426,932	6.00
7.00	00700	OPERATION OF PLANT	952,412	0	0	952,412	217,235	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	105,824	20,519	18,033	144,376	32,931	8.00
9.00	00900	HOUSEKEEPING	601,853	31,739	98,037	731,629	166,877	9.00
10.00	01000	DIETARY	49,341	17,349	14,606	81,296	18,543	10.00
11.00	01100	CAFETERIA	673,357	79,433	51,118	803,908	183,363	11.00
13.00	01300	NURSING ADMINISTRATION	638,261	4,607	194,859	837,727	191,076	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,591	2,451	16,801	67,843	15,474	14.00
15.00	01500	PHARMACY	1,082,798	30,936	245,826	1,359,560	310,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	609,417	33,979	132,526	775,922	176,979	16.00
17.00	01700	SOCIAL SERVICE	300,888	11,601	83,179	395,668	90,248	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,758,609	485,072	730,333	3,974,014	906,429	30.00
43.00	04300	NURSERY	135,495	14,095	48,858	198,448	45,264	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,771,764	214,738	357,460	2,343,962	534,632	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	75,850	37,445	27,351	140,646	32,080	52.00
53.00	05300	ANESTHESIOLOGY	150,104	0	23,966	174,070	39,703	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,865,407	135,960	333,812	2,335,179	532,629	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	203,229	0	49,997	253,226	57,758	55.01
60.00	06000	LABORATORY	3,371,126	73,622	106,672	3,551,420	810,040	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	94,793	0	0	94,793	21,621	62.00
65.00	06500	RESPIRATORY THERAPY	778,758	70,114	162,545	1,011,417	230,693	65.00
66.00	06600	PHYSICAL THERAPY	713,254	116,751	243,414	1,073,419	244,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,778	2,451	79,431	282,660	64,472	67.00
68.00	06800	SPEECH PATHOLOGY	170,077	0	42,200	212,277	48,418	68.00
69.00	06900	ELECTROCARDIOLOGY	248,321	0	69,347	317,668	72,457	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,621,767	0	0	1,621,767	369,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	741,863	0	0	741,863	169,211	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,081,047	0	0	6,081,047	1,387,003	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,940,171	267,925	791,364	3,999,460	912,233	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,658,633	197,029	671,378	3,527,040	804,479	88.01
90.00	09000	CLINIC	405,690	106,207	100,190	612,087	139,610	90.00
90.01	09001	ONCOLOGY	389,870	80,912	102,109	572,891	130,670	90.01
90.02	09002	OUTPATIENT CLINIC	140,356	0	40,607	180,963	41,276	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1,960	25,358	541	27,859	6,354	90.05
90.06	09006	CLINIC	329,305	34,508	65,303	429,116	97,877	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	221,964	73,960	47,089	343,013	78,237	90.07
90.08	09008	PAIN MANAGEMENT	183,524	8,685	0	192,209	43,841	90.08
90.09	09009	GERIATRIC PSYCH	410,904	44,080	10,300	465,284	106,126	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	87,530	32,902	22,928	143,360	32,699	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	35,037	22,209	10,068	67,314	15,354	90.11
90.12	09012	DIABETES CLINIC	6,810	5,050	1,367	13,227	3,017	90.12
90.13	09013	NEUROLOGY	4,876	5,346	1,298	11,520	2,628	90.13
90.14	09014	FOOT AND ANKLE	23,179	1,754	5,059	29,992	6,841	90.14
91.00	09100	EMERGENCY	2,328,191	110,179	353,131	2,791,501	636,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,068,122	76,073	278,179	1,422,374	324,428	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,866,535	3,209,652	7,061,274	59,045,884	10,779,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	579,330	22,399	58,322	660,051	150,550	194.00
194.02	07952	NRCC	0	606,368	0	606,368	138,306	194.02
194.05	07955	RETAIL PHARMACY	3,016,654	16,863	116,699	3,150,216	718,530	194.05
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)	63,462,519	3,855,282	7,236,295	63,462,519	11,786,678	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	2,298,711					6.00
7.00	00700	OPERATION OF PLANT	0	1,169,647				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,691	184,998			8.00
9.00	00900	HOUSEKEEPING	197,032	11,896	26,151	1,133,585		9.00
10.00	01000	DIETARY	0	6,502	1,120	0	107,461	10.00
11.00	01100	CAFETERIA	0	29,772	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	35,365	1,727	0	1,629	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	919	0	0	0	14.00
15.00	01500	PHARMACY	0	11,595	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,261	12,736	0	2,444	0	16.00
17.00	01700	SOCIAL SERVICE	55,573	4,348	0	2,601	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,042	181,808	68,541	605,105	95,134	30.00
43.00	04300	NURSERY	0	5,283	1,952	20,699	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	101,042	80,485	22,634	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,104	14,035	82	38,252	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,313	50,959	13,579	32,712	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	0	0	0	0	55.01
60.00	06000	LABORATORY	10,104	27,594	0	24,033	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	171,772	26,279	3,500	17,234	0	65.00
66.00	06600	PHYSICAL THERAPY	106,094	43,759	9,979	10,497	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	919	0	6,329	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,104	0	0	4,982	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,031	3,885	0	69.00
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	45,469	0	0	37,224	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,111,465	100,420	1,613	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	30,313	73,848	314	0	0	88.01
90.00	09000	CLINIC	0	39,807	0	0	0	90.00
90.01	09001	ONCOLOGY	35,365	30,326	611	75,702	3,351	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	594	5,264	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	10,104	9,504	0	0	0	90.05
90.06	09006	CLINIC	10,104	12,934	2,210	18,268	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	85,886	27,721	838	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0	3,255	0	0	0	90.08
90.09	09009	GERIATRIC PSYCH	55,573	16,522	0	0	7,636	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	12,332	0	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	8,324	0	0	0	90.11
90.12	09012	DIABETES CLINIC	0	1,893	0	0	0	90.12
90.13	09013	NEUROLOGY	0	2,004	0	0	0	90.13
90.14	09014	FOOT AND ANKLE	0	657	0	0	0	90.14
91.00	09100	EMERGENCY	35,365	41,296	28,091	207,517	1,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	28,513	1,158	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,273,450	927,663	184,998	1,114,377	107,461	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	MARKETING	25,261	8,395	0	0	0	194.00
194.02	07952	NRCC	0	227,269	0	19,208	0	194.02
194.05	07955	RETAIL PHARMACY	0	6,320	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,298,711	1,169,647	184,998	1,133,585	107,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/22/2021 8:27 pm

		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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,017,043					11.00
13.00	01300	NURSING ADMINISTRATION	18,707	1,086,231				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,718	23,285	114,239			14.00
15.00	01500	PHARMACY	0	0	0	1,681,256		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,488	0	0	0	1,027,830	16.00
17.00	01700	SOCIAL SERVICE	15,641	54,381	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	119,697	388,868	0	0	44,576	30.00
43.00	04300	NURSERY	5,208	18,125	0	0	3,742	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,286	216,093	0	0	88,002	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,915	10,146	0	0	4,581	52.00
53.00	05300	ANESTHESIOLOGY	10,818	0	0	0	7,382	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,410	0	0	0	148,182	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	6,846	0	0	0	25,062	55.01
60.00	06000	LABORATORY	24,427	8,757	0	0	136,109	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	2,713	62.00
65.00	06500	RESPIRATORY THERAPY	27,736	94,695	0	0	19,991	65.00
66.00	06600	PHYSICAL THERAPY	42,687	0	0	0	30,034	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,783	0	0	0	11,944	67.00
68.00	06800	SPEECH PATHOLOGY	5,065	0	0	0	6,583	68.00
69.00	06900	ELECTROCARDIOLOGY	11,472	39,928	0	0	27,216	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	78,383	0	19,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	35,856	0	9,754	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,417	0	0	1,261,098	166,100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	119,800	0	0	0	14,030	88.00
88.01	08801	RURAL HEALTH CLINIC II	86,435	0	0	0	13,576	88.01
90.00	09000	CLINIC	43,962	0	0	0	10,613	90.00
90.01	09001	ONCOLOGY	20,155	0	0	0	17,931	90.01
90.02	09002	OUTPATIENT CLINIC	17,157	0	0	0	1,763	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	46	90.05
90.06	09006	CLINIC	12,955	45,111	0	0	19,740	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	22,808	0	0	0	1,009	90.07
90.08	09008	PAIN MANAGEMENT	9,889	0	0	0	16,416	90.08
90.09	09009	GERIATRIC PSYCH	3,515	0	0	0	7,689	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	13,437	0	0	0	1,413	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	4,789	0	0	0	274	90.11
90.12	09012	DIABETES CLINIC	0	0	0	0	114	90.12
90.13	09013	NEUROLOGY	2,584	0	0	0	192	90.13
90.14	09014	FOOT AND ANKLE	4,272	0	0	0	536	90.14
91.00	09100	EMERGENCY	59,393	186,842	0	0	139,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	71,282	0	0	0	31,660	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	992,754	1,086,231	114,239	1,261,098	1,027,830	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	MARKETING	8,648	0	0	0	0	194.00
194.02	07952	NRCC	0	0	0	0	0	194.02
194.05	07955	RETAIL PHARMACY	15,641	0	0	420,158	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,017,043	1,086,231	114,239	1,681,256	1,027,830	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
17.00	01700	SOCIAL SERVICE	618,460					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	552,711	7,037,925	0	7,037,925		30.00
43.00	04300	NURSERY	0	298,721	0	298,721		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,454,136	0	3,454,136		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	252,841	0	252,841		52.00
53.00	05300	ANESTHESIOLOGY	0	231,973	0	231,973		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,197,963	0	3,197,963		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0		55.00
55.01	03630	ULTRA SOUND	0	342,892	0	342,892		55.01
60.00	06000	LABORATORY	0	4,592,484	0	4,592,484		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	119,127	0	119,127		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,603,317	0	1,603,317		65.00
66.00	06600	PHYSICAL THERAPY	0	1,561,304	0	1,561,304		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	377,107	0	377,107		67.00
68.00	06800	SPEECH PATHOLOGY	0	287,429	0	287,429		68.00
69.00	06900	ELECTROCARDIOLOGY	0	474,657	0	474,657		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,089,164	0	2,089,164		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	956,684	0	956,684		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,013,358	0	9,013,358		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,259,021	0	6,259,021		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,536,005	0	4,536,005		88.01
90.00	09000	CLINIC	0	846,079	0	846,079		90.00
90.01	09001	ONCOLOGY	33,958	920,960	0	920,960		90.01
90.02	09002	OUTPATIENT CLINIC	9,393	256,410	0	256,410		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	53,867	0	53,867		90.05
90.06	09006	CLINIC	0	648,315	0	648,315		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	559,512	0	559,512		90.07
90.08	09008	PAIN MANAGEMENT	0	265,610	0	265,610		90.08
90.09	09009	GERIATRIC PSYCH	0	662,345	0	662,345		90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	203,241	0	203,241		90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	96,055	0	96,055		90.11
90.12	09012	DIABETES CLINIC	0	18,251	0	18,251		90.12
90.13	09013	NEUROLOGY	0	18,928	0	18,928		90.13
90.14	09014	FOOT AND ANKLE	0	42,298	0	42,298		90.14
91.00	09100	EMERGENCY	22,398	4,150,204	0	4,150,204		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,879,415	0	1,879,415		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	618,460	57,307,598	0	57,307,598		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	MARKETING	0	852,905	0	852,905		194.00
194.02	07952	NRCC	0	991,151	0	991,151		194.02
194.05	07955	RETAIL PHARMACY	0	4,310,865	0	4,310,865		194.05
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	618,460	63,462,519	0	63,462,519		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	50,060	50,060	50,060		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	269,405	269,405	9,119	278,524	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	415,148	415,148	767	10,089	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	5,134	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,519	20,519	125	778	8.00
9.00	00900	HOUSEKEEPING	0	31,739	31,739	678	3,943	9.00
10.00	01000	DIETARY	0	17,349	17,349	101	438	10.00
11.00	01100	CAFETERIA	0	79,433	79,433	354	4,333	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,607	4,607	1,348	4,515	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,451	2,451	116	366	14.00
15.00	01500	PHARMACY	0	30,936	30,936	1,701	7,328	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,979	33,979	917	4,182	16.00
17.00	01700	SOCIAL SERVICE	0	11,601	11,601	576	2,133	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	485,072	485,072	5,053	21,420	30.00
43.00	04300	NURSERY	0	14,095	14,095	338	1,070	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	214,738	214,738	2,473	12,634	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,445	37,445	189	758	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	166	938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	135,960	135,960	2,310	12,587	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	0	0	346	1,365	55.01
60.00	06000	LABORATORY	0	73,622	73,622	738	19,142	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	511	62.00
65.00	06500	RESPIRATORY THERAPY	0	70,114	70,114	1,125	5,452	65.00
66.00	06600	PHYSICAL THERAPY	0	116,751	116,751	1,684	5,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,451	2,451	550	1,524	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	292	1,144	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	480	1,712	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,999	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	32,766	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	267,925	267,925	5,475	21,557	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	197,029	197,029	4,645	19,011	88.01
90.00	09000	CLINIC	0	106,207	106,207	693	3,299	90.00
90.01	09001	ONCOLOGY	0	80,912	80,912	706	3,088	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0	281	975	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	25,358	25,358	4	150	90.05
90.06	09006	CLINIC	0	34,508	34,508	452	2,313	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	73,960	73,960	326	1,849	90.07
90.08	09008	PAIN MANAGEMENT	0	8,685	8,685	0	1,036	90.08
90.09	09009	GERIATRIC PSYCH	0	44,080	44,080	71	2,508	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	32,902	32,902	159	773	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	22,209	22,209	70	363	90.11
90.12	09012	DIABETES CLINIC	0	5,050	5,050	9	71	90.12
90.13	09013	NEUROLOGY	0	5,346	5,346	9	62	90.13
90.14	09014	FOOT AND ANKLE	0	1,754	1,754	35	162	90.14
91.00	09100	EMERGENCY	0	110,179	110,179	2,443	15,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	76,073	76,073	1,925	7,667	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,209,652	3,209,652	48,849	254,718	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	MARKETING	0	22,399	22,399	404	3,558	194.00
194.02	07952	NRCC	0	606,368	606,368	0	3,268	194.02
194.05	07955	RETAIL PHARMACY	0	16,863	16,863	807	16,980	194.05
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	3,855,282	3,855,282	50,060	278,524	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	426,004					6.00
7.00	00700	OPERATION OF PLANT	0	5,134				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34	21,456			8.00
9.00	00900	HOUSEKEEPING	36,515	52	3,033	75,960		9.00
10.00	01000	DIETARY	0	29	130	0	18,047	10.00
11.00	01100	CAFETERIA	0	131	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,554	8	0	109	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4	0	0	0	14.00
15.00	01500	PHARMACY	0	51	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,681	56	0	164	0	16.00
17.00	01700	SOCIAL SERVICE	10,299	19	0	174	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,725	798	7,951	40,549	15,977	30.00
43.00	04300	NURSERY	0	23	226	1,387	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,725	353	2,625	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,873	62	9	2,563	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,618	224	1,575	2,192	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	0	0	0	0	55.01
60.00	06000	LABORATORY	1,873	121	0	1,610	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	31,833	115	406	1,155	0	65.00
66.00	06600	PHYSICAL THERAPY	19,662	192	1,157	703	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4	0	424	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,873	0	0	334	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	236	260	0	69.00
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	8,426	0	0	2,494	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	205,978	441	187	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,618	324	36	0	0	88.01
90.00	09000	CLINIC	0	175	0	0	0	90.00
90.01	09001	ONCOLOGY	6,554	133	71	5,073	563	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	69	353	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1,873	42	0	0	0	90.05
90.06	09006	CLINIC	1,873	57	256	1,224	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	15,917	122	97	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0	14	0	0	0	90.08
90.09	09009	GERIATRIC PSYCH	10,299	73	0	0	1,282	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	54	0	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	37	0	0	0	90.11
90.12	09012	DIABETES CLINIC	0	8	0	0	0	90.12
90.13	09013	NEUROLOGY	0	9	0	0	0	90.13
90.14	09014	FOOT AND ANKLE	0	3	0	0	0	90.14
91.00	09100	EMERGENCY	6,554	181	3,258	13,905	225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	125	134	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	421,323	4,074	21,456	74,673	18,047	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	MARKETING	4,681	37	0	0	0	194.00
194.02	07952	NRCC	0	995	0	1,287	0	194.02
194.05	07955	RETAIL PHARMACY	0	28	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	426,004	5,134	21,456	75,960	18,047	202.00

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		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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	84,251					11.00
13.00	01300	NURSING ADMINISTRATION	1,550	18,691				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	557	401	3,895			14.00
15.00	01500	PHARMACY	0	0	0	40,016		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,857	0	0	0	46,836	16.00
17.00	01700	SOCIAL SERVICE	1,296	936	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,916	6,691	0	0	2,028	30.00
43.00	04300	NURSERY	431	312	0	0	170	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,574	3,718	0	0	4,005	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	241	175	0	0	208	52.00
53.00	05300	ANESTHESIOLOGY	896	0	0	0	336	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,507	0	0	0	6,743	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	567	0	0	0	1,140	55.01
60.00	06000	LABORATORY	2,023	151	0	0	6,194	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	123	62.00
65.00	06500	RESPIRATORY THERAPY	2,298	1,629	0	0	910	65.00
66.00	06600	PHYSICAL THERAPY	3,536	0	0	0	1,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	893	0	0	0	544	67.00
68.00	06800	SPEECH PATHOLOGY	420	0	0	0	300	68.00
69.00	06900	ELECTROCARDIOLOGY	950	687	0	0	1,238	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,672	0	869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,223	0	444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,934	0	0	30,015	7,625	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,925	0	0	0	638	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,160	0	0	0	618	88.01
90.00	09000	CLINIC	3,642	0	0	0	483	90.00
90.01	09001	ONCOLOGY	1,670	0	0	0	816	90.01
90.02	09002	OUTPATIENT CLINIC	1,421	0	0	0	80	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	2	90.05
90.06	09006	CLINIC	1,073	776	0	0	898	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	1,889	0	0	0	46	90.07
90.08	09008	PAIN MANAGEMENT	819	0	0	0	747	90.08
90.09	09009	GERIATRIC PSYCH	291	0	0	0	350	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1,113	0	0	0	64	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	397	0	0	0	12	90.11
90.12	09012	DIABETES CLINIC	0	0	0	0	5	90.12
90.13	09013	NEUROLOGY	214	0	0	0	9	90.13
90.14	09014	FOOT AND ANKLE	354	0	0	0	24	90.14
91.00	09100	EMERGENCY	4,920	3,215	0	0	6,359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,905	0	0	0	1,441	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,239	18,691	3,895	30,015	46,836	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	MARKETING	716	0	0	0	0	194.00
194.02	07952	NRCC	0	0	0	0	0	194.02
194.05	07955	RETAIL PHARMACY	1,296	0	0	10,001	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	84,251	18,691	3,895	40,016	46,836	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
17.00	01700	SOCIAL SERVICE	27,034					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,160	638,340	0	638,340		30.00
43.00	04300	NURSERY	0	18,052	0	18,052		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	264,845	0	264,845		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	43,523	0	43,523		52.00
53.00	05300	ANESTHESIOLOGY	0	2,336	0	2,336		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171,716	0	171,716		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0		55.00
55.01	03630	ULTRA SOUND	0	3,418	0	3,418		55.01
60.00	06000	LABORATORY	0	105,474	0	105,474		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	634	0	634		62.00
65.00	06500	RESPIRATORY THERAPY	0	115,037	0	115,037		65.00
66.00	06600	PHYSICAL THERAPY	0	150,838	0	150,838		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,390	0	6,390		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,363	0	4,363		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,563	0	5,563		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,282	0	12,282		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,666	0	5,666		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	84,260	0	84,260		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	512,126	0	512,126		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	234,441	0	234,441		88.01
90.00	09000	CLINIC	0	114,499	0	114,499		90.00
90.01	09001	ONCOLOGY	1,484	101,070	0	101,070		90.01
90.02	09002	OUTPATIENT CLINIC	411	3,590	0	3,590		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	27,429	0	27,429		90.05
90.06	09006	CLINIC	0	43,430	0	43,430		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	94,206	0	94,206		90.07
90.08	09008	PAIN MANAGEMENT	0	11,301	0	11,301		90.08
90.09	09009	GERIATRIC PSYCH	0	58,954	0	58,954		90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	35,065	0	35,065		90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	23,088	0	23,088		90.11
90.12	09012	DIABETES CLINIC	0	5,143	0	5,143		90.12
90.13	09013	NEUROLOGY	0	5,649	0	5,649		90.13
90.14	09014	FOOT AND ANKLE	0	2,332	0	2,332		90.14
91.00	09100	EMERGENCY	979	167,264	0	167,264		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	93,270	0	93,270		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,034	3,165,594	0	3,165,594		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	MARKETING	0	31,795	0	31,795		194.00
194.02	07952	NRCC	0	611,918	0	611,918		194.02
194.05	07955	RETAIL PHARMACY	0	45,975	0	45,975		194.05
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	27,034	3,855,282	0	3,855,282		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (TIME SPENT)	
			1.00	4.00	5A	5.00	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	182,443					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,369	25,108,810				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,749	4,577,011	-11,786,678	51,675,841		5.00
6.00	00600	MAINTENANCE & REPAIRS	19,646	384,805	0	1,871,779	455	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	952,412	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	62,572	0	144,376	0	8.00
9.00	00900	HOUSEKEEPING	1,502	340,172	0	731,629	39	9.00
10.00	01000	DIETARY	821	50,682	0	81,296	0	10.00
11.00	01100	CAFETERIA	3,759	177,373	0	803,908	0	11.00
13.00	01300	NURSING ADMINISTRATION	218	676,130	0	837,727	7	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	116	58,298	0	67,843	0	14.00
15.00	01500	PHARMACY	1,464	852,978	0	1,359,560	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,608	459,846	0	775,922	5	16.00
17.00	01700	SOCIAL SERVICE	549	288,618	0	395,668	11	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,955	2,534,145	0	3,974,014	20	30.00
43.00	04300	NURSERY	667	169,531	0	198,448	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,162	1,240,331	0	2,343,962	20	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,772	94,903	0	140,646	2	52.00
53.00	05300	ANESTHESIOLOGY	0	83,159	0	174,070	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,434	1,158,278	0	2,335,179	6	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	173,483	0	253,226	0	55.01
60.00	06000	LABORATORY	3,484	370,134	0	3,551,420	2	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	94,793	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,318	564,006	0	1,011,417	34	65.00
66.00	06600	PHYSICAL THERAPY	5,525	844,610	0	1,073,419	21	66.00
67.00	06700	OCCUPATIONAL THERAPY	116	275,614	0	282,660	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	146,428	0	212,277	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	240,623	0	317,668	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,621,767	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	741,863	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,081,047	9	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,679	2,745,915	0	3,999,460	220	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,324	2,329,581	0	3,527,040	6	88.01
90.00	09000	CLINIC	5,026	347,644	0	612,087	0	90.00
90.01	09001	ONCOLOGY	3,829	354,302	0	572,891	7	90.01
90.02	09002	OUTPATIENT CLINIC	0	140,900	0	180,963	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1,200	1,876	0	27,859	2	90.05
90.06	09006	CLINIC	1,633	226,590	0	429,116	2	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3,500	163,391	0	343,013	17	90.07
90.08	09008	PAIN MANAGEMENT	411	0	0	192,209	0	90.08
90.09	09009	GERIATRIC PSYCH	2,086	35,738	0	465,284	11	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1,557	79,556	0	143,360	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	1,051	34,936	0	67,314	0	90.11
90.12	09012	DIABETES CLINIC	239	4,744	0	13,227	0	90.12
90.13	09013	NEUROLOGY	253	4,505	0	11,520	0	90.13
90.14	09014	FOOT AND ANKLE	83	17,553	0	29,992	0	90.14
91.00	09100	EMERGENCY	5,214	1,225,312	0	2,791,501	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,600	965,240	0	1,422,374	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	151,890	24,501,513	-11,786,678	47,259,206	450	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	MARKETING	1,060	202,368	0	660,051	5	194.00
194.02	07952	NRCC	28,695	0	0	606,368	0	194.02
194.05	07955	RETAIL PHARMACY	798	404,929	0	3,150,216	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,855,282	7,236,295		11,786,678	2,298,711	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (TIME SPENT)	
			1.00	4.00	5A	5.00	6.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	21.131433	0.288197		0.228089	5,052.112088	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		50,060		278,524	426,004	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001994		0.005390	936.272527	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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	147,679					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	258,695				8.00
9.00	00900	HOUSEKEEPING	1,502	36,569	180,889			9.00
10.00	01000	DIETARY	821	1,566	0	11,385		10.00
11.00	01100	CAFETERIA	3,759	0	0	0	614,015	11.00
13.00	01300	NURSING ADMINISTRATION	218	0	260	0	11,294	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	116	0	0	0	4,056	14.00
15.00	01500	PHARMACY	1,464	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,608	0	390	0	20,821	16.00
17.00	01700	SOCIAL SERVICE	549	0	415	0	9,443	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,955	95,843	96,558	10,079	72,264	30.00
43.00	04300	NURSERY	667	2,729	3,303	0	3,144	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,162	31,651	0	0	40,622	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,772	114	6,104	0	1,760	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	6,531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,434	18,989	5,220	0	32,849	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	0	0	0	4,133	55.01
60.00	06000	LABORATORY	3,484	0	3,835	0	14,747	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,318	4,894	2,750	0	16,745	65.00
66.00	06600	PHYSICAL THERAPY	5,525	13,955	1,675	0	25,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	116	0	1,010	0	6,510	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	795	0	3,058	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,840	620	0	6,926	69.00
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	5,940	0	21,382	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,679	2,256	0	0	72,328	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,324	439	0	0	52,183	88.01
90.00	09000	CLINIC	5,026	0	0	0	26,541	90.00
90.01	09001	ONCOLOGY	3,829	855	12,080	355	12,168	90.01
90.02	09002	OUTPATIENT CLINIC	0	831	840	0	10,358	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1,200	0	0	0	0	90.05
90.06	09006	CLINIC	1,633	3,091	2,915	0	7,821	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3,500	1,172	0	0	13,770	90.07
90.08	09008	PAIN MANAGEMENT	411	0	0	0	5,970	90.08
90.09	09009	GERIATRIC PSYCH	2,086	0	0	809	2,122	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1,557	0	0	0	8,112	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	1,051	0	0	0	2,891	90.11
90.12	09012	DIABETES CLINIC	239	0	0	0	0	90.12
90.13	09013	NEUROLOGY	253	0	0	0	1,560	90.13
90.14	09014	FOOT AND ANKLE	83	0	0	0	2,579	90.14
91.00	09100	EMERGENCY	5,214	39,281	33,114	142	35,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,600	1,620	0	0	43,035	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,126	258,695	177,824	11,385	599,351	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	MARKETING	1,060	0	0	0	5,221	194.00
194.02	07952	NRCC	28,695	0	3,065	0	0	194.02
194.05	07955	RETAIL PHARMACY	798	0	0	0	9,443	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,169,647	184,998	1,133,585	107,461	1,017,043	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.920199	0.715120	6.266744	9.438823	1.656381	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	5,134	21,456	75,960	18,047	84,251	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.034765	0.082939	0.419926	1.585156	0.137213	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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	188,420					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,039	2,363,630				14.00
15.00	01500	PHARMACY	0	0	10,237,327			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	130,292,695		16.00
17.00	01700	SOCIAL SERVICE	9,433	0	0	0	856	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,454	0	0	5,650,388	765	30.00
43.00	04300	NURSERY	3,144	0	0	474,351	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,484	0	0	11,155,054	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,760	0	0	580,626	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	935,697	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,783,347	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	0	0	3,176,778	0	55.01
60.00	06000	LABORATORY	1,519	0	0	17,252,964	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	343,876	0	62.00
65.00	06500	RESPIRATORY THERAPY	16,426	0	0	2,534,055	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,807,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,513,970	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	834,510	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,926	0	0	3,449,851	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,621,767	0	2,421,970	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	741,863	0	1,236,438	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,678,945	21,061,239	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,778,372	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,720,897	0	88.01
90.00	09000	CLINIC	0	0	0	1,345,324	0	90.00
90.01	09001	ONCOLOGY	0	0	0	2,272,873	47	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0	223,472	13	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	5,819	0	90.05
90.06	09006	CLINIC	7,825	0	0	2,502,234	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0	127,871	0	90.07
90.08	09008	PAIN MANAGEMENT	0	0	0	2,080,912	0	90.08
90.09	09009	GERIATRIC PSYCH	0	0	0	974,674	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	0	0	179,050	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	0	0	34,707	0	90.11
90.12	09012	DIABETES CLINIC	0	0	0	14,415	0	90.12
90.13	09013	NEUROLOGY	0	0	0	24,311	0	90.13
90.14	09014	FOOT AND ANKLE	0	0	0	67,995	0	90.14
91.00	09100	EMERGENCY	32,410	0	0	17,714,484	31	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	4,013,141	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	188,420	2,363,630	7,678,945	130,292,695	856	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	MARKETING	0	0	0	0	0	194.00
194.02	07952	NRCC	0	0	0	0	0	194.02
194.05	07955	RETAIL PHARMACY	0	0	2,558,382	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,086,231	114,239	1,681,256	1,027,830	618,460	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.764945	0.048332	0.164228	0.007889	722.500000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/22/2021 8:27 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	18,691	3,895	40,016	46,836	27,034	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.099199	0.001648	0.003909	0.000359	31.581776	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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,037,925		7,037,925	0	0	30.00
43.00	04300	NURSERY	298,721		298,721	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,454,136		3,454,136	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	252,841		252,841	0	0	52.00
53.00	05300	ANESTHESIOLOGY	231,973		231,973	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,197,963		3,197,963	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0		0	0	0	55.00
55.01	03630	ULTRA SOUND	342,892		342,892	0	0	55.01
60.00	06000	LABORATORY	4,592,484		4,592,484	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	119,127		119,127	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,603,317	0	1,603,317	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,561,304	0	1,561,304	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	377,107	0	377,107	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	287,429	0	287,429	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	474,657		474,657	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,089,164		2,089,164	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	956,684		956,684	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,013,358		9,013,358	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,259,021		6,259,021	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,536,005		4,536,005	0	0	88.01
90.00	09000	CLINIC	846,079		846,079	0	0	90.00
90.01	09001	ONCOLOGY	920,960		920,960	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	256,410		256,410	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0		0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0		0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	53,867		53,867	0	0	90.05
90.06	09006	CLINIC	648,315		648,315	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	559,512		559,512	0	0	90.07
90.08	09008	PAIN MANAGEMENT	265,610		265,610	0	0	90.08
90.09	09009	GERIATRIC PSYCH	662,345		662,345	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	203,241		203,241	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	96,055		96,055	0	0	90.11
90.12	09012	DIABETES CLINIC	18,251		18,251	0	0	90.12
90.13	09013	NEUROLOGY	18,928		18,928	0	0	90.13
90.14	09014	FOOT AND ANKLE	42,298		42,298	0	0	90.14
91.00	09100	EMERGENCY	4,150,204		4,150,204	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,150,682		1,150,682		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,879,415		1,879,415	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	58,458,280	0	58,458,280	0	0	200.00
201.00		Less Observation Beds	1,150,682		1,150,682		0	201.00
202.00		Total (see instructions)	57,307,598	0	57,307,598	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,731,374		4,731,374			30.00
43.00	04300	NURSERY	474,351		474,351			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,742,953	9,412,101	11,155,054	0.309648	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	465,564	115,062	580,626	0.435463	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	122,666	813,031	935,697	0.247915	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	841,988	17,941,359	18,783,347	0.170255	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	03630	ULTRA SOUND	97,105	3,079,673	3,176,778	0.107937	0.000000	55.01
60.00	06000	LABORATORY	944,312	16,308,652	17,252,964	0.266185	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	129,786	214,090	343,876	0.346424	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,373,059	1,160,996	2,534,055	0.632708	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	475,327	3,331,703	3,807,030	0.410111	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	468,719	1,045,251	1,513,970	0.249085	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	100,458	734,052	834,510	0.344428	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	347,013	3,102,838	3,449,851	0.137588	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	880,911	1,541,059	2,421,970	0.862589	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	417,726	818,712	1,236,438	0.773742	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,665,850	17,395,389	21,061,239	0.427960	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,778,372	1,778,372			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,720,897	1,720,897			88.01
90.00	09000	CLINIC	0	1,345,324	1,345,324	0.628904	0.000000	90.00
90.01	09001	ONCOLOGY	1,118	2,271,755	2,272,873	0.405196	0.000000	90.01
90.02	09002	OUTPATIENT CLINIC	48,141	175,331	223,472	1.147392	0.000000	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0.000000	0.000000	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0.000000	0.000000	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	5,819	5,819	9.257089	0.000000	90.05
90.06	09006	CLINIC	9,769	2,492,465	2,502,234	0.259094	0.000000	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	798	127,073	127,871	4.375597	0.000000	90.07
90.08	09008	PAIN MANAGEMENT	0	2,080,912	2,080,912	0.127641	0.000000	90.08
90.09	09009	GERIATRIC PSYCH	0	974,674	974,674	0.679555	0.000000	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	179,050	179,050	1.135108	0.000000	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	34,707	34,707	2.767597	0.000000	90.11
90.12	09012	DIABETES CLINIC	0	14,415	14,415	1.266112	0.000000	90.12
90.13	09013	NEUROLOGY	0	24,311	24,311	0.778578	0.000000	90.13
90.14	09014	FOOT AND ANKLE	0	67,995	67,995	0.622075	0.000000	90.14
91.00	09100	EMERGENCY	19,590	17,694,894	17,714,484	0.234283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,475	916,539	919,014	1.252083	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,013,141	4,013,141	0.468315	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	17,361,053	112,931,642	130,292,695			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,361,053	112,931,642	130,292,695			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
55.01	03630	ULTRA SOUND	0.000000	55.01
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
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
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	ONCOLOGY	0.000000	90.01
90.02	09002	OUTPATIENT CLINIC	0.000000	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0.000000	90.05
90.06	09006	CLINIC	0.000000	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0.000000	90.07
90.08	09008	PAIN MANAGEMENT	0.000000	90.08
90.09	09009	GERIATRIC PSYCH	0.000000	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0.000000	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0.000000	90.11
90.12	09012	DIABETES CLINIC	0.000000	90.12
90.13	09013	NEUROLOGY	0.000000	90.13
90.14	09014	FOOT AND ANKLE	0.000000	90.14
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/22/2021 8:27 pm

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	7,037,925		7,037,925	0	7,037,925	30.00
43.00	04300	NURSERY	298,721		298,721	0	298,721	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,454,136		3,454,136	0	3,454,136	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	252,841		252,841	0	252,841	52.00
53.00	05300	ANESTHESIOLOGY	231,973		231,973	0	231,973	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,197,963		3,197,963	0	3,197,963	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0		0	0	0	55.00
55.01	03630	ULTRA SOUND	342,892		342,892	0	342,892	55.01
60.00	06000	LABORATORY	4,592,484		4,592,484	0	4,592,484	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	119,127		119,127	0	119,127	62.00
65.00	06500	RESPIRATORY THERAPY	1,603,317	0	1,603,317	0	1,603,317	65.00
66.00	06600	PHYSICAL THERAPY	1,561,304	0	1,561,304	0	1,561,304	66.00
67.00	06700	OCCUPATIONAL THERAPY	377,107	0	377,107	0	377,107	67.00
68.00	06800	SPEECH PATHOLOGY	287,429	9,026	296,455	0	296,455	68.00
69.00	06900	ELECTROCARDIOLOGY	474,657		474,657	0	474,657	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,089,164		2,089,164	0	2,089,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	956,684		956,684	0	956,684	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,013,358		9,013,358	0	9,013,358	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,259,021		6,259,021	0	6,259,021	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,536,005		4,536,005	0	4,536,005	88.01
90.00	09000	CLINIC	846,079		846,079	0	846,079	90.00
90.01	09001	ONCOLOGY	920,960		920,960	0	920,960	90.01
90.02	09002	OUTPATIENT CLINIC	256,410		256,410	0	256,410	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0		0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0		0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	53,867		53,867	0	53,867	90.05
90.06	09006	CLINIC	648,315		648,315	0	648,315	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	559,512		559,512	0	559,512	90.07
90.08	09008	PAIN MANAGEMENT	265,610		265,610	0	265,610	90.08
90.09	09009	GERIATRIC PSYCH	662,345		662,345	0	662,345	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	203,241		203,241	0	203,241	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	96,055		96,055	0	96,055	90.11
90.12	09012	DIABETES CLINIC	18,251		18,251	0	18,251	90.12
90.13	09013	NEUROLOGY	18,928		18,928	0	18,928	90.13
90.14	09014	FOOT AND ANKLE	42,298		42,298	0	42,298	90.14
91.00	09100	EMERGENCY	4,150,204		4,150,204	0	4,150,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,150,682		1,150,682		1,150,682	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,879,415		1,879,415	0	1,879,415	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	58,458,280	0	58,467,306	0	58,467,306	200.00
201.00		Less Observation Beds	1,150,682		1,150,682		1,150,682	201.00
202.00		Total (see instructions)	57,307,598	0	57,316,624	0	57,316,624	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/22/2021 8:27 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,731,374		4,731,374			30.00
43.00	04300	NURSERY	474,351		474,351			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,742,953	9,412,101	11,155,054	0.309648	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	465,564	115,062	580,626	0.435463	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	122,666	813,031	935,697	0.247915	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	841,988	17,941,359	18,783,347	0.170255	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	03630	ULTRA SOUND	97,105	3,079,673	3,176,778	0.107937	0.000000	55.01
60.00	06000	LABORATORY	944,312	16,308,652	17,252,964	0.266185	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	129,786	214,090	343,876	0.346424	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,373,059	1,160,996	2,534,055	0.632708	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	475,327	3,331,703	3,807,030	0.410111	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	468,719	1,045,251	1,513,970	0.249085	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	100,458	734,052	834,510	0.344428	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	347,013	3,102,838	3,449,851	0.137588	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	880,911	1,541,059	2,421,970	0.862589	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	417,726	818,712	1,236,438	0.773742	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,665,850	17,395,389	21,061,239	0.427960	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,778,372	1,778,372	3.519523	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,720,897	1,720,897	2.635838	0.000000	88.01
90.00	09000	CLINIC	0	1,345,324	1,345,324	0.628904	0.000000	90.00
90.01	09001	ONCOLOGY	1,118	2,271,755	2,272,873	0.405196	0.000000	90.01
90.02	09002	OUTPATIENT CLINIC	48,141	175,331	223,472	1.147392	0.000000	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0.000000	0.000000	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0.000000	0.000000	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	5,819	5,819	9.257089	0.000000	90.05
90.06	09006	CLINIC	9,769	2,492,465	2,502,234	0.259094	0.000000	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	798	127,073	127,871	4.375597	0.000000	90.07
90.08	09008	PAIN MANAGEMENT	0	2,080,912	2,080,912	0.127641	0.000000	90.08
90.09	09009	GERIATRIC PSYCH	0	974,674	974,674	0.679555	0.000000	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	179,050	179,050	1.135108	0.000000	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	34,707	34,707	2.767597	0.000000	90.11
90.12	09012	DIABETES CLINIC	0	14,415	14,415	1.266112	0.000000	90.12
90.13	09013	NEUROLOGY	0	24,311	24,311	0.778578	0.000000	90.13
90.14	09014	FOOT AND ANKLE	0	67,995	67,995	0.622075	0.000000	90.14
91.00	09100	EMERGENCY	19,590	17,694,894	17,714,484	0.234283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,475	916,539	919,014	1.252083	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,013,141	4,013,141	0.468315	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	17,361,053	112,931,642	130,292,695			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,361,053	112,931,642	130,292,695			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/22/2021 8:27 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.309648		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435463		52.00
53.00	05300	ANESTHESIOLOGY	0.247915		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170255		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		55.00
55.01	03630	ULTRA SOUND	0.107937		55.01
60.00	06000	LABORATORY	0.266185		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.346424		62.00
65.00	06500	RESPIRATORY THERAPY	0.632708		65.00
66.00	06600	PHYSICAL THERAPY	0.410111		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249085		67.00
68.00	06800	SPEECH PATHOLOGY	0.355244		68.00
69.00	06900	ELECTROCARDIOLOGY	0.137588		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.862589		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.773742		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427960		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	3.519523		88.00
88.01	08801	RURAL HEALTH CLINIC II	2.635838		88.01
90.00	09000	CLINIC	0.628904		90.00
90.01	09001	ONCOLOGY	0.405196		90.01
90.02	09002	OUTPATIENT CLINIC	1.147392		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	9.257089		90.05
90.06	09006	CLINIC	0.259094		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	4.375597		90.07
90.08	09008	PAIN MANAGEMENT	0.127641		90.08
90.09	09009	GERIATRIC PSYCH	0.679555		90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1.135108		90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	2.767597		90.11
90.12	09012	DIABETES CLINIC	1.266112		90.12
90.13	09013	NEUROLOGY	0.778578		90.13
90.14	09014	FOOT AND ANKLE	0.622075		90.14
91.00	09100	EMERGENCY	0.234283		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252083		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.468315		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 6/22/2021 8:27 pm

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	3,454,136	264,845	3,189,291	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	252,841	43,523	209,318	0	0	52.00
53.00	05300	ANESTHESIOLOGY	231,973	2,336	229,637	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,197,963	171,716	3,026,247	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	342,892	3,418	339,474	0	0	55.01
60.00	06000	LABORATORY	4,592,484	105,474	4,487,010	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	119,127	634	118,493	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,603,317	115,037	1,488,280	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,561,304	150,838	1,410,466	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	377,107	6,390	370,717	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	287,429	4,363	283,066	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	474,657	5,563	469,094	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,089,164	12,282	2,076,882	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	956,684	5,666	951,018	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,013,358	84,260	8,929,098	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,259,021	512,126	5,746,895	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,536,005	234,441	4,301,564	0	0	88.01
90.00	09000	CLINIC	846,079	114,499	731,580	0	0	90.00
90.01	09001	ONCOLOGY	920,960	101,070	819,890	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	256,410	3,590	252,820	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	53,867	27,429	26,438	0	0	90.05
90.06	09006	CLINIC	648,315	43,430	604,885	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	559,512	94,206	465,306	0	0	90.07
90.08	09008	PAIN MANAGEMENT	265,610	11,301	254,309	0	0	90.08
90.09	09009	GERIATRIC PSYCH	662,345	58,954	603,391	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	203,241	35,065	168,176	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	96,055	23,088	72,967	0	0	90.11
90.12	09012	DIABETES CLINIC	18,251	5,143	13,108	0	0	90.12
90.13	09013	NEUROLOGY	18,928	5,649	13,279	0	0	90.13
90.14	09014	FOOT AND ANKLE	42,298	2,332	39,966	0	0	90.14
91.00	09100	EMERGENCY	4,150,204	167,264	3,982,940	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,150,682	104,367	1,046,315	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,879,415	93,270	1,786,145	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	51,121,634	2,613,569	48,508,065	0	0	200.00
201.00		Less Observation Beds	1,150,682	104,367	1,046,315	0	0	201.00
202.00		Total (line 200 minus line 201)	49,970,952	2,509,202	47,461,750	0	0	202.00

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

Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 6/22/2021 8:27 pm

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	3,454,136	11,155,054	0.309648		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	252,841	580,626	0.435463		52.00
53.00	05300	ANESTHESIOLOGY	231,973	935,697	0.247915		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,197,963	18,783,347	0.170255		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000		55.00
55.01	03630	ULTRA SOUND	342,892	3,176,778	0.107937		55.01
60.00	06000	LABORATORY	4,592,484	17,252,964	0.266185		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	119,127	343,876	0.346424		62.00
65.00	06500	RESPIRATORY THERAPY	1,603,317	2,534,055	0.632708		65.00
66.00	06600	PHYSICAL THERAPY	1,561,304	3,807,030	0.410111		66.00
67.00	06700	OCCUPATIONAL THERAPY	377,107	1,513,970	0.249085		67.00
68.00	06800	SPEECH PATHOLOGY	287,429	834,510	0.344428		68.00
69.00	06900	ELECTROCARDIOLOGY	474,657	3,449,851	0.137588		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,089,164	2,421,970	0.862589		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	956,684	1,236,438	0.773742		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,013,358	21,061,239	0.427960		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	6,259,021	1,778,372	3.519523		88.00
88.01	08801	RURAL HEALTH CLINIC II	4,536,005	1,720,897	2.635838		88.01
90.00	09000	CLINIC	846,079	1,345,324	0.628904		90.00
90.01	09001	ONCOLOGY	920,960	2,272,873	0.405196		90.01
90.02	09002	OUTPATIENT CLINIC	256,410	223,472	1.147392		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0.000000		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0.000000		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	53,867	5,819	9.257089		90.05
90.06	09006	CLINIC	648,315	2,502,234	0.259094		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	559,512	127,871	4.375597		90.07
90.08	09008	PAIN MANAGEMENT	265,610	2,080,912	0.127641		90.08
90.09	09009	GERIATRIC PSYCH	662,345	974,674	0.679555		90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	203,241	179,050	1.135108		90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	96,055	34,707	2.767597		90.11
90.12	09012	DIABETES CLINIC	18,251	14,415	1.266112		90.12
90.13	09013	NEUROLOGY	18,928	24,311	0.778578		90.13
90.14	09014	FOOT AND ANKLE	42,298	67,995	0.622075		90.14
91.00	09100	EMERGENCY	4,150,204	17,714,484	0.234283		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,150,682	919,014	1.252083		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,879,415	4,013,141	0.468315		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
200.00		Subtotal (sum of lines 50 thru 199)	51,121,634	125,086,970			200.00
201.00		Less Observation Beds	1,150,682	0			201.00
202.00		Total (line 200 minus line 201)	49,970,952	125,086,970			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 6/22/2021 8:27 pm

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	264,845	11,155,054	0.023742	431,639	10,248	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,523	580,626	0.074959	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,336	935,697	0.002497	46,213	115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,716	18,783,347	0.009142	434,328	3,971	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	03630	ULTRA SOUND	3,418	3,176,778	0.001076	47,453	51	55.01
60.00	06000	LABORATORY	105,474	17,252,964	0.006113	377,628	2,308	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	634	343,876	0.001844	39,404	73	62.00
65.00	06500	RESPIRATORY THERAPY	115,037	2,534,055	0.045396	687,690	31,218	65.00
66.00	06600	PHYSICAL THERAPY	150,838	3,807,030	0.039621	190,694	7,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,390	1,513,970	0.004221	185,453	783	67.00
68.00	06800	SPEECH PATHOLOGY	4,363	834,510	0.005228	29,483	154	68.00
69.00	06900	ELECTROCARDIOLOGY	5,563	3,449,851	0.001613	170,481	275	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,282	2,421,970	0.005071	384,088	1,948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,666	1,236,438	0.004583	269,133	1,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,260	21,061,239	0.004001	1,564,455	6,259	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	512,126	1,778,372	0.287975	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	234,441	1,720,897	0.136232	0	0	88.01
90.00	09000	CLINIC	114,499	1,345,324	0.085109	0	0	90.00
90.01	09001	ONCOLOGY	101,070	2,272,873	0.044468	68	3	90.01
90.02	09002	OUTPATIENT CLINIC	3,590	223,472	0.016065	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0.000000	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0.000000	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	27,429	5,819	4.713697	0	0	90.05
90.06	09006	CLINIC	43,430	2,502,234	0.017356	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	94,206	127,871	0.736727	798	588	90.07
90.08	09008	PAIN MANAGEMENT	11,301	2,080,912	0.005431	0	0	90.08
90.09	09009	GERIATRIC PSYCH	58,954	974,674	0.060486	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	35,065	179,050	0.195839	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	23,088	34,707	0.665226	0	0	90.11
90.12	09012	DIABETES CLINIC	5,143	14,415	0.356781	0	0	90.12
90.13	09013	NEUROLOGY	5,649	24,311	0.232364	0	0	90.13
90.14	09014	FOOT AND ANKLE	2,332	67,995	0.034297	0	0	90.14
91.00	09100	EMERGENCY	167,264	17,714,484	0.009442	8,189	77	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	104,367	919,014	0.113564	741	84	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,520,299	121,073,829		4,867,938	66,943	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/22/2021 8:27 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	0	0	0	0	55.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	0	90.05
90.06	09006	CLINIC	0	0	0	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0	0	0	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0	0	0	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	0	0	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	0	0	0	0	90.11
90.12	09012	DIABETES CLINIC	0	0	0	0	0	90.12
90.13	09013	NEUROLOGY	0	0	0	0	0	90.13
90.14	09014	FOOT AND ANKLE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/22/2021 8:27 pm

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	11,155,054	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	580,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	935,697	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,783,347	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	03630	ULTRA SOUND	0	0	0	3,176,778	0.000000	55.01
60.00	06000	LABORATORY	0	0	0	17,252,964	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	343,876	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,534,055	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,807,030	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,513,970	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	834,510	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,449,851	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,421,970	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,236,438	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,061,239	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,778,372	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,720,897	0.000000	88.01
90.00	09000	CLINIC	0	0	0	1,345,324	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	2,272,873	0.000000	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0	223,472	0.000000	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0.000000	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0.000000	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	5,819	0.000000	90.05
90.06	09006	CLINIC	0	0	0	2,502,234	0.000000	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0	127,871	0.000000	90.07
90.08	09008	PAIN MANAGEMENT	0	0	0	2,080,912	0.000000	90.08
90.09	09009	GERIATRIC PSYCH	0	0	0	974,674	0.000000	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	0	0	179,050	0.000000	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	0	0	34,707	0.000000	90.11
90.12	09012	DIABETES CLINIC	0	0	0	14,415	0.000000	90.12
90.13	09013	NEUROLOGY	0	0	0	24,311	0.000000	90.13
90.14	09014	FOOT AND ANKLE	0	0	0	67,995	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	17,714,484	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	919,014	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	121,073,829		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/22/2021 8:27 pm

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	431,639	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	46,213	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	434,328	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0.000000	47,453	0	0	0	55.01
60.00	06000	LABORATORY	0.000000	377,628	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	39,404	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	687,690	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	190,694	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	185,453	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	29,483	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	170,481	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	384,088	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	269,133	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,564,455	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0.000000	68	0	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0.000000	0	0	0	0	90.05
90.06	09006	CLINIC	0.000000	0	0	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0.000000	798	0	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0.000000	0	0	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0.000000	0	0	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0.000000	0	0	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0.000000	0	0	0	0	90.11
90.12	09012	DIABETES CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	NEUROLOGY	0.000000	0	0	0	0	90.13
90.14	09014	FOOT AND ANKLE	0.000000	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.000000	8,189	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	741	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,867,938	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/22/2021 8:27 pm

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	0.309648	0	1,903,926	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435463	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.247915	0	172,636	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170255	0	4,614,632	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0.107937	0	965,495	0	0	55.01
60.00	06000	LABORATORY	0.266185	0	4,120,191	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.346424	0	52,068	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.632708	0	369,099	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.410111	0	877,404	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249085	0	159,453	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.344428	0	76,878	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137588	0	909,701	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.862589	0	350,552	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.773742	0	171,499	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427960	0	6,404,983	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.628904	0	75,744	0	0	90.00
90.01	09001	ONCOLOGY	0.405196	0	849,213	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	1.147392	0	42,665	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	9.257089	0	354	0	0	90.05
90.06	09006	CLINIC	0.259094	0	764,037	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	4.375597	0	4,884	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0.127641	0	0	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0.679555	0	871,560	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1.135108	0	22,959	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	2.767597	0	4,817	0	0	90.11
90.12	09012	DIABETES CLINIC	1.266112	0	309	0	0	90.12
90.13	09013	NEUROLOGY	0.778578	0	2,003	0	0	90.13
90.14	09014	FOOT AND ANKLE	0.622075	0	2,706	0	0	90.14
91.00	09100	EMERGENCY	0.234283	0	3,633,259	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252083	0	256,069	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.468315		0			95.00
200.00		Subtotal (see instructions)		0	27,679,096	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	27,679,096	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	589,547	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,799	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	785,664	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
55.01	03630	ULTRA SOUND	104,213	0	55.01
60.00	06000	LABORATORY	1,096,733	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	18,038	0	62.00
65.00	06500	RESPIRATORY THERAPY	233,532	0	65.00
66.00	06600	PHYSICAL THERAPY	359,833	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,717	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,479	0	68.00
69.00	06900	ELECTROCARDIOLOGY	125,164	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	302,382	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	132,696	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,741,077	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	47,636	0	90.00
90.01	09001	ONCOLOGY	344,098	0	90.01
90.02	09002	OUTPATIENT CLINIC	48,953	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	3,277	0	90.05
90.06	09006	CLINIC	197,957	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	21,370	0	90.07
90.08	09008	PAIN MANAGEMENT	0	0	90.08
90.09	09009	GERIATRIC PSYCH	592,273	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	26,061	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	13,332	0	90.11
90.12	09012	DIABETES CLINIC	391	0	90.12
90.13	09013	NEUROLOGY	1,559	0	90.13
90.14	09014	FOOT AND ANKLE	1,683	0	90.14
91.00	09100	EMERGENCY	851,211	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	320,620	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	9,068,295	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	9,068,295	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 6/22/2021 8:27 pm

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	638,340	44,931	593,409	3,764	157.65	30.00
43.00	NURSERY	18,052		18,052	393	45.93	43.00
200.00	Total (lines 30 through 199)	656,392		611,461	4,157		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	135	21,283	30.00
43.00	NURSERY	239	10,977	43.00
200.00	Total (lines 30 through 199)	374	32,260	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 6/22/2021 8:27 pm

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	264,845	11,155,054	0.023742	71,318	1,693	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,523	580,626	0.074959	19,050	1,428	52.00
53.00	05300	ANESTHESIOLOGY	2,336	935,697	0.002497	5,019	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,716	18,783,347	0.009142	34,452	315	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	03630	ULTRA SOUND	3,418	3,176,778	0.001076	3,973	4	55.01
60.00	06000	LABORATORY	105,474	17,252,964	0.006113	38,639	236	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	634	343,876	0.001844	5,311	10	62.00
65.00	06500	RESPIRATORY THERAPY	115,037	2,534,055	0.045396	56,183	2,550	65.00
66.00	06600	PHYSICAL THERAPY	150,838	3,807,030	0.039621	19,449	771	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,390	1,513,970	0.004221	19,179	81	67.00
68.00	06800	SPEECH PATHOLOGY	4,363	834,510	0.005228	4,111	21	68.00
69.00	06900	ELECTROCARDIOLOGY	5,563	3,449,851	0.001613	14,199	23	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,282	2,421,970	0.005071	36,045	183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,666	1,236,438	0.004583	17,093	78	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,260	21,061,239	0.004001	149,999	600	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	512,126	1,778,372	0.287975	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	234,441	1,720,897	0.136232	0	0	88.01
90.00	09000	CLINIC	114,499	1,345,324	0.085109	0	0	90.00
90.01	09001	ONCOLOGY	101,070	2,272,873	0.044468	46	2	90.01
90.02	09002	OUTPATIENT CLINIC	3,590	223,472	0.016065	1,970	32	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0.000000	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0.000000	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	27,429	5,819	4.713697	0	0	90.05
90.06	09006	CLINIC	43,430	2,502,234	0.017356	400	7	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	94,206	127,871	0.736727	0	0	90.07
90.08	09008	PAIN MANAGEMENT	11,301	2,080,912	0.005431	0	0	90.08
90.09	09009	GERIATRIC PSYCH	58,954	974,674	0.060486	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	35,065	179,050	0.195839	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	23,088	34,707	0.665226	0	0	90.11
90.12	09012	DIABETES CLINIC	5,143	14,415	0.356781	0	0	90.12
90.13	09013	NEUROLOGY	5,649	24,311	0.232364	0	0	90.13
90.14	09014	FOOT AND ANKLE	2,332	67,995	0.034297	0	0	90.14
91.00	09100	EMERGENCY	167,264	17,714,484	0.009442	802	8	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	104,367	919,014	0.113564	101	11	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,520,299	121,073,829		497,339	8,066	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 6/22/2021 8:27 pm

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
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	3,764	0.00	135	30.00
43.00	04300	NURSERY		0	393	0.00	239	43.00
200.00		Total (lines 30 through 199)		0	4,157		374	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
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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/22/2021 8:27 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0	0	0	0	0	55.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	0	90.05
90.06	09006	CLINIC	0	0	0	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0	0	0	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0	0	0	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	0	0	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	0	0	0	0	90.11
90.12	09012	DIABETES CLINIC	0	0	0	0	0	90.12
90.13	09013	NEUROLOGY	0	0	0	0	0	90.13
90.14	09014	FOOT AND ANKLE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/22/2021 8:27 pm

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	11,155,054	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	580,626	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	935,697	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,783,347	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0.000000	55.00
55.01	03630	ULTRA SOUND	0	0	0	3,176,778	0.000000	55.01
60.00	06000	LABORATORY	0	0	0	17,252,964	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	343,876	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,534,055	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,807,030	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,513,970	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	834,510	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,449,851	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,421,970	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,236,438	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,061,239	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,778,372	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,720,897	0.000000	88.01
90.00	09000	CLINIC	0	0	0	1,345,324	0.000000	90.00
90.01	09001	ONCOLOGY	0	0	0	2,272,873	0.000000	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0	223,472	0.000000	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0.000000	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0.000000	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	5,819	0.000000	90.05
90.06	09006	CLINIC	0	0	0	2,502,234	0.000000	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0	127,871	0.000000	90.07
90.08	09008	PAIN MANAGEMENT	0	0	0	2,080,912	0.000000	90.08
90.09	09009	GERIATRIC PSYCH	0	0	0	974,674	0.000000	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0	0	0	179,050	0.000000	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0	0	0	34,707	0.000000	90.11
90.12	09012	DIABETES CLINIC	0	0	0	14,415	0.000000	90.12
90.13	09013	NEUROLOGY	0	0	0	24,311	0.000000	90.13
90.14	09014	FOOT AND ANKLE	0	0	0	67,995	0.000000	90.14
91.00	09100	EMERGENCY	0	0	0	17,714,484	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	919,014	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	121,073,829		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/22/2021 8:27 pm

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	71,318	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	19,050	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	5,019	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	34,452	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0.000000	3,973	0	0	0	55.01
60.00	06000	LABORATORY	0.000000	38,639	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	5,311	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	56,183	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	19,449	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	19,179	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,111	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,199	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	36,045	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	17,093	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	149,999	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0.000000	46	0	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0.000000	1,970	0	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0.000000	0	0	0	0	90.05
90.06	09006	CLINIC	0.000000	400	0	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0.000000	0	0	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0.000000	0	0	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0.000000	0	0	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	0.000000	0	0	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	0.000000	0	0	0	0	90.11
90.12	09012	DIABETES CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	NEUROLOGY	0.000000	0	0	0	0	90.13
90.14	09014	FOOT AND ANKLE	0.000000	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.000000	802	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	101	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		497,339	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/22/2021 8:27 pm

Title XIX | Hospital | PPS

		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	0.309648	0	198,208	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435463	0	2,423	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.247915	0	17,121	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170255	0	377,824	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	03630	ULTRA SOUND	0.107937	0	64,854	0	0	55.01
60.00	06000	LABORATORY	0.266185	0	343,441	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.346424	0	4,508	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.632708	0	24,449	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.410111	0	70,162	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249085	0	22,012	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.344428	0	15,458	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137588	0	65,342	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.862589	0	32,453	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.773742	0	17,241	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427960	0	366,326	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.628904	0	28,331	0	0	90.00
90.01	09001	ONCOLOGY	0.405196	0	47,840	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	1.147392	0	3,692	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	9.257089	0	123	0	0	90.05
90.06	09006	CLINIC	0.259094	0	52,488	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	4.375597	0	2,693	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0.127641	0	43,822	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0.679555	0	20,525	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1.135108	0	3,771	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	2.767597	0	731	0	0	90.11
90.12	09012	DIABETES CLINIC	1.266112	0	304	0	0	90.12
90.13	09013	NEUROLOGY	0.778578	0	512	0	0	90.13
90.14	09014	FOOT AND ANKLE	0.622075	0	1,432	0	0	90.14
91.00	09100	EMERGENCY	0.234283	0	372,633	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252083	0	19,301	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.468315	0	84,512			95.00
200.00		Subtotal (see instructions)		0	2,304,532	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	2,304,532	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/22/2021 8:27 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	61,375	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,055	0		52.00
53.00	05300	ANESTHESIOLOGY	4,245	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,326	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
55.01	03630	ULTRA SOUND	7,000	0		55.01
60.00	06000	LABORATORY	91,419	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,562	0		62.00
65.00	06500	RESPIRATORY THERAPY	15,469	0		65.00
66.00	06600	PHYSICAL THERAPY	28,774	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,483	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,324	0		68.00
69.00	06900	ELECTROCARDIOLOGY	8,990	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,994	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,340	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	156,773	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	17,817	0		90.00
90.01	09001	ONCOLOGY	19,385	0		90.01
90.02	09002	OUTPATIENT CLINIC	4,236	0		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1,139	0		90.05
90.06	09006	CLINIC	13,599	0		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	11,783	0		90.07
90.08	09008	PAIN MANAGEMENT	5,593	0		90.08
90.09	09009	GERIATRIC PSYCH	13,948	0		90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	4,280	0		90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	2,023	0		90.11
90.12	09012	DIABETES CLINIC	385	0		90.12
90.13	09013	NEUROLOGY	399	0		90.13
90.14	09014	FOOT AND ANKLE	891	0		90.14
91.00	09100	EMERGENCY	87,302	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	24,166	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	39,578			95.00
200.00		Subtotal (see instructions)	739,653	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	739,653	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,085	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,764	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)	3,102	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	285	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	36	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,513	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)	246	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,037,925	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)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	495,384	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,542,541	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)	6,542,541	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,738.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,629,881	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,629,881	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/22/2021 8:27 pm

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						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)	2,146,910	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,776,791	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)	427,595	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	427,595	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	662	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,738.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,150,682	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	638,340	7,037,925	0.090700	1,150,682	104,367	90.00
91.00	Nursing School cost	0	7,037,925	0.000000	1,150,682	0	91.00
92.00	Allied health cost	0	7,037,925	0.000000	1,150,682	0	92.00
93.00	All other Medical Education	0	7,037,925	0.000000	1,150,682	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/22/2021 8:27 pm

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)	4,085	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,764	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)	3,102	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	285	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	36	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	135	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)	393	15.00
16.00	Nursery days (title V or XIX only)	239	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,037,925	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)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	495,384	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,542,541	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)	6,542,541	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,738.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	234,656	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)	234,656	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/22/2021 8:27 pm

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)	298,721	393	760.10	239	181,664	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	212,966	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	629,286	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)	32,260	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,066	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	40,326	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	588,960	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)	662	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,738.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,150,682	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/22/2021 8:27 pm

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	638,340	7,037,925	0.090700	1,150,682	104,367	90.00
91.00	Nursing School cost	0	7,037,925	0.000000	1,150,682	0	91.00
92.00	Allied health cost	0	7,037,925	0.000000	1,150,682	0	92.00
93.00	All other Medical Education	0	7,037,925	0.000000	1,150,682	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,155,123		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.309648	431,639	133,656	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435463	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.247915	46,213	11,457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170255	434,328	73,947	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	55.00
55.01	03630	ULTRA SOUND	0.107937	47,453	5,122	55.01
60.00	06000	LABORATORY	0.266185	377,628	100,519	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.346424	39,404	13,650	62.00
65.00	06500	RESPIRATORY THERAPY	0.632708	687,690	435,107	65.00
66.00	06600	PHYSICAL THERAPY	0.410111	190,694	78,206	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249085	185,453	46,194	67.00
68.00	06800	SPEECH PATHOLOGY	0.344428	29,483	10,155	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137588	170,481	23,456	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.862589	384,088	331,310	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.773742	269,133	208,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427960	1,564,455	669,524	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.628904	0	0	90.00
90.01	09001	ONCOLOGY	0.405196	68	28	90.01
90.02	09002	OUTPATIENT CLINIC	1.147392	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	9.257089	0	0	90.05
90.06	09006	CLINIC	0.259094	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	4.375597	798	3,492	90.07
90.08	09008	PAIN MANAGEMENT	0.127641	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0.679555	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1.135108	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	2.767597	0	0	90.11
90.12	09012	DIABETES CLINIC	1.266112	0	0	90.12
90.13	09013	NEUROLOGY	0.778578	0	0	90.13
90.14	09014	FOOT AND ANKLE	0.622075	0	0	90.14
91.00	09100	EMERGENCY	0.234283	8,189	1,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252083	741	928	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,867,938	2,146,910	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)		4,867,938		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1332 | Component CCN: 15-Z332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.309648	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435463	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.247915	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170255	3,464	590	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	55.00
55.01	03630	ULTRA SOUND	0.107937	754	81	55.01
60.00	06000	LABORATORY	0.266185	9,301	2,476	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.346424	1,208	418	62.00
65.00	06500	RESPIRATORY THERAPY	0.632708	15,942	10,087	65.00
66.00	06600	PHYSICAL THERAPY	0.410111	97,691	40,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249085	96,582	24,057	67.00
68.00	06800	SPEECH PATHOLOGY	0.344428	1,932	665	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137588	258	35	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.862589	23,657	20,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.773742	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427960	66,472	28,447	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.628904	0	0	90.00
90.01	09001	ONCOLOGY	0.405196	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	1.147392	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	9.257089	0	0	90.05
90.06	09006	CLINIC	0.259094	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	4.375597	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0.127641	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0.679555	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1.135108	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	2.767597	0	0	90.11
90.12	09012	DIABETES CLINIC	1.266112	0	0	90.12
90.13	09013	NEUROLOGY	0.778578	0	0	90.13
90.14	09014	FOOT AND ANKLE	0.622075	0	0	90.14
91.00	09100	EMERGENCY	0.234283	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252083	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		317,261	127,326	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)		317,261		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/22/2021 8:27 pm

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		193,598		30.00
43.00	04300	NURSERY		19,409		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.309648	71,318	22,083	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.435463	19,050	8,296	52.00
53.00	05300	ANESTHESIOLOGY	0.247915	5,019	1,244	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170255	34,452	5,866	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	55.00
55.01	03630	ULTRA SOUND	0.107937	3,973	429	55.01
60.00	06000	LABORATORY	0.266185	38,639	10,285	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.346424	5,311	1,840	62.00
65.00	06500	RESPIRATORY THERAPY	0.632708	56,183	35,547	65.00
66.00	06600	PHYSICAL THERAPY	0.410111	19,449	7,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249085	19,179	4,777	67.00
68.00	06800	SPEECH PATHOLOGY	0.355244	4,111	1,460	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137588	14,199	1,954	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.862589	36,045	31,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.773742	17,093	13,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.427960	149,999	64,194	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3.519523	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.635838	0	0	88.01
90.00	09000	CLINIC	0.628904	0	0	90.00
90.01	09001	ONCOLOGY	0.405196	46	19	90.01
90.02	09002	OUTPATIENT CLINIC	1.147392	1,970	2,260	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	9.257089	0	0	90.05
90.06	09006	CLINIC	0.259094	400	104	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	4.375597	0	0	90.07
90.08	09008	PAIN MANAGEMENT	0.127641	0	0	90.08
90.09	09009	GERIATRIC PSYCH	0.679555	0	0	90.09
90.10	09010	PROVIDER BASED CLINIC - DCPM	1.135108	0	0	90.10
90.11	09011	PROVIDER BASED CLINIC - NEPHROLOGY	2.767597	0	0	90.11
90.12	09012	DIABETES CLINIC	1.266112	0	0	90.12
90.13	09013	NEUROLOGY	0.778578	0	0	90.13
90.14	09014	FOOT AND ANKLE	0.622075	0	0	90.14
91.00	09100	EMERGENCY	0.234283	802	188	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.252083	101	126	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		497,339	212,966	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)		497,339		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 6/22/2021 8:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,068,295	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,068,295	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,158,978	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)	116,467	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,680,246	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)	4,362,265	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)	4,362,265	30.00
31.00	Primary payer payments	1,594	31.00
32.00	Subtotal (line 30 minus line 31)	4,360,671	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)	512,770	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	333,301	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	402,137	36.00
37.00	Subtotal (see instructions)	4,693,972	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)	4,693,972	40.00
40.01	Sequestration adjustment (see instructions)	30,980	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	3,476,398	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)	1,186,594	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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,472,752		3,476,398	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	07/09/2020	133,000		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)		133,000		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)		3,605,752		3,476,398	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		806,719		1,186,594	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,412,471		4,662,992	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: 15-1332 | Component CCN: 15-Z332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		472,062		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		472,062		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		82,611		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		554,673		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: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 6/22/2021 8:27 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1332 | Component CCN: 15-Z332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 6/22/2021 8:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	431,871	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)	128,599	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	246	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)	560,470	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	560,470	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)	560,470	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,112	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	558,358	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)	558,358	0	19.00
19.01	Sequestration adjustment (see instructions)	3,685	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	472,062	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)	82,611	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: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 6/22/2021 8:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,776,791	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)	4,776,791	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,824,559	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)	4,824,559	19.00
20.00	Deductibles (exclude professional component)	439,120	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,385,439	22.00
23.00	Coinsurance	2,816	23.00
24.00	Subtotal (line 22 minus line 23)	4,382,623	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	91,021	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	59,164	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,518	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,441,787	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)	4,441,787	30.00
30.01	Sequestration adjustment (see instructions)	29,316	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,605,752	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)	806,719	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 6/22/2021 8:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,697,536	0	0	0	1.00
2.00	Temporary investments	41,078,677	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,121,217	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,742,757	0	0	0	6.00
7.00	Inventory	1,636,541	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	6,534,000	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)	64,325,214	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,550,209	0	0	0	12.00
13.00	Land improvements	620,290	0	0	0	13.00
14.00	Accumulated depreciation	-473,398	0	0	0	14.00
15.00	Buildings	41,835,075	0	0	0	15.00
16.00	Accumulated depreciation	-19,316,170	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	3,977,566	0	0	0	19.00
20.00	Accumulated depreciation	-2,895,492	0	0	0	20.00
21.00	Automobiles and trucks	267,458	0	0	0	21.00
22.00	Accumulated depreciation	-157,290	0	0	0	22.00
23.00	Major movable equipment	32,108,024	0	0	0	23.00
24.00	Accumulated depreciation	-22,291,468	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)	37,224,804	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,532	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,532	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	101,557,550	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,289,149	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,291,495	0	0	0	38.00
39.00	Payroll taxes payable	1,254,741	0	0	0	39.00
40.00	Notes and loans payable (short term)	556,271	0	0	0	40.00
41.00	Deferred income	1,600,000	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-4,543,753	0	0	0	43.00
44.00	Other current liabilities	4,475,892	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,923,795	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,985,734	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,961,405	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,947,139	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,870,934	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	78,686,616				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)	78,686,616	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	101,557,550	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 6/22/2021 8:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		64,148,844		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,526,020				2.00
3.00	Total (sum of line 1 and line 2)		77,674,864		0		3.00
4.00	CHANGE IN UPL TRANSFER	7,811,752		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)		7,811,752		0		10.00
11.00	Subtotal (line 3 plus line 10)		85,486,616		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)		85,486,616		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	CHANGE IN UPL TRANSFER		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: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/22/2021 8:27 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,804,875		6,804,875	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)	6,804,875		6,804,875	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,804,875		6,804,875	17.00
18.00	Ancillary services	13,814,049	121,713,895	135,527,944	18.00
19.00	Outpatient services	0	669,525	669,525	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER REVENUE	1,759,144	128,792	1,887,936	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,378,068	122,512,212	144,890,280	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		76,949,427		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)		76,949,427		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1332 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 6/22/2021 8:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	144,890,280	1.00
2.00	Less contractual allowances and discounts on patients' accounts	83,468,982	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,421,298	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	76,949,427	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-15,528,129	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUES	29,019,416	24.00
24.50	COVID-19 PHE Funding	34,733	24.50
25.00	Total other income (sum of lines 6-24)	29,054,149	25.00
26.00	Total (line 5 plus line 25)	13,526,020	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)	13,526,020	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1332 | Component CCN: 15-8522 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/22/2021 8:27 pm

RHC I

		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	967,824	0	967,824	-35,519	932,305	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	590,018	0	590,018	-37,230	552,788	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	554,098	0	554,098	0	554,098	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	34,620	0	34,620	0	34,620	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)	2,146,560	0	2,146,560	-72,749	2,073,811	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	49,912	49,912	0	49,912	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	49,912	49,912	0	49,912	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,146,560	49,912	2,196,472	-72,749	2,123,723	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	83,721	83,721	0	83,721	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	72,749	72,749	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	83,721	83,721	72,749	156,470	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	11,896	11,896	0	11,896	29.00
30.00	Administrative Costs	296,217	66,084	362,301	0	362,301	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	296,217	77,980	374,197	0	374,197	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,442,777	211,613	2,654,390	0	2,654,390	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1332 | Component CCN: 15-8522 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/22/2021 8:27 pm

RHC I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	73,584	1,005,889		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	780	553,568		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	554,098		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	-18,541	16,079		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)	55,823	2,129,634		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	49,912		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	49,912		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	55,823	2,179,546		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	83,721		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	72,749		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	156,470		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	11,896		29.00
30.00	Administrative Costs	229,958	592,259		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	229,958	604,155		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	285,781	2,940,171		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1332 | Component CCN: 15-8521 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/22/2021 8:27 pm

RHC II

		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	1,318,334	0	1,318,334	-97,557	1,220,777	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	360,319	0	360,319	-5,405	354,914	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	351,338	0	351,338	0	351,338	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)	2,029,991	0	2,029,991	-102,962	1,927,029	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	42,677	42,677	0	42,677	15.00
16.00	Transportation (Health Care Staff)	0	144	144	0	144	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	42,821	42,821	0	42,821	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,029,991	42,821	2,072,812	-102,962	1,969,850	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	178,640	178,640	0	178,640	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	102,962	102,962	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	178,640	178,640	102,962	281,602	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	8,595	8,595	0	8,595	29.00
30.00	Administrative Costs	316,521	79,270	395,791	0	395,791	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	316,521	87,865	404,386	0	404,386	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,346,512	309,326	2,655,838	0	2,655,838	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1332 | Component CCN: 15-8521 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/22/2021 8:27 pm

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-73,584	1,147,193		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-780	354,134		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	351,338		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	18,541	18,541		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)	-55,823	1,871,206		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	42,677		15.00
16.00	Transportation (Health Care Staff)	0	144		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	42,821		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-55,823	1,914,027		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	178,640		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	102,962		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	281,602		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	8,595		29.00
30.00	Administrative Costs	58,618	454,409		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	58,618	463,004		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,795	2,658,633		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1332 | Component CCN: 15-8522 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 6/22/2021 8:27 pm

RHC I

		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	3.56	8,647	1	4		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	5.15	8,855	1	5		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.71	17,502		9	17,502	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	0.24	31			31	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)	8.95	17,533			17,533	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)					2,179,546	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					156,470	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,336,016	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.933018	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					604,155	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,318,850	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,923,005	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,923,005	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,660,234	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,839,780	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1332 | Component CCN: 15-8521 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 6/22/2021 8:27 pm

RHC II

		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	3.31	10,811	1	3		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	2.62	6,338	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.93	17,149		6	17,149	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	0.28	37			37	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)	6.21	17,186			17,186	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,914,027	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					281,602	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,195,629	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.871744	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					463,004	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,877,372	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,340,376	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,340,376	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,040,209	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,954,236	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1332 Component CCN: 15-8522	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 6/22/2021 8:27 pm
	Title XVIII	RHC I	

			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)		5,839,780	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		87,368	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		5,752,412	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		17,533	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)		17,533	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		328.09	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)	86.31	86.31	8.00
9.00	Rate for Program covered visits (see instructions)	328.09	328.09	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,388	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,767,749	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	1,767,749	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,023,368	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		92,783	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		160,271	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.)		1,220,522	16.04
16.05	Total program cost (see instructions)	0	1,380,793	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		81,825	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		163,126	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,380,793	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		28,717	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,409,510	22.00
23.00	Allowable bad debts (see instructions)		7,071	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		4,596	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,339	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)		1,414,106	26.00
26.01	Sequestration adjustment (see instructions)		9,333	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		864,440	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)		540,333	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: 15-1332 Component CCN: 15-8521	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 6/22/2021 8:27 pm
	Title XVIII	RHC II	

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,954,236	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		176,718	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,777,518	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		17,186	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)		17,186	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		219.80	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)	86.31	86.31	8.00
9.00	Rate for Program covered visits (see instructions)	219.80	219.80	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,171	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	916,786	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	916,786	16.00
16.01	Total program charges (see instructions)(from contractor's records)		817,962	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		39,805	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		44,614	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.)		629,364	16.04
16.05	Total program cost (see instructions)	0	673,978	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		85,467	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		137,310	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		673,978	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		41,098	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		715,076	22.00
23.00	Allowable bad debts (see instructions)		7,759	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		5,043	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,782	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)		720,119	26.00
26.01	Sequestration adjustment (see instructions)		4,753	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		446,523	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)		268,843	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: 15-1332 Component CCN: 15-8522	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 6/22/2021 8:27 pm
	Title XVIII	RHC I	

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,129,634	2,129,634	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000439	0.001561	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	935	3,324	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	15,953	12,396	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	16,888	15,720	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,179,546	2,179,546	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,660,234	3,660,234	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.007748	0.007213	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	28,359	26,401	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	45,247	42,121	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	131	466	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	345.40	90.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	52	119	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	17,961	10,756	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)		87,368	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		28,717	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1332 Component CCN: 15-8521	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 6/22/2021 8:27 pm
	Title XVIII	RHC II	

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,871,206	1,871,206	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001750	0.005739	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,275	10,739	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	45,802	25,723	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	49,077	36,462	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,914,027	1,914,027	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,040,209	2,040,209	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.025641	0.019050	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	52,313	38,866	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	101,390	75,328	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	325	1,066	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	311.97	70.66	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	81	224	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	25,270	15,828	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		176,718	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)		41,098	16.00

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

Provider CCN: 15-1332
Component CCN: 15-8522

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

Worksheet M-5

Date/Time Prepared: 6/22/2021 8:27 pm

RHC I

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		814,740	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		07/14/2020	49,700	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)		49,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		864,440	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		540,333	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,404,773	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: 15-1332
Component CCN: 15-8521

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

Worksheet M-5

Date/Time Prepared: 6/22/2021 8:27 pm

RHC II

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		446,523	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)		446,523	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		268,843	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		715,366	7.00

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