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: 15-1324	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 9:26 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/2/2021 Time: 9:26 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH RENSSELAER (15-1324) 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	-156,555	-1,251,937	0	16,868	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	-313,538	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		17,543		0	10.00
10.03	RURAL HEALTH CLINIC IV	0		-6,113		0	10.03
200.00	Total	0	-470,093	-1,240,507	0	16,868	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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:26 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1104 EAST GRACE STREET	PO Box:			1.00
2.00	City: RENSSELAER	State: IN	Zip Code: 47978-	County: JASPER	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	FRANCISCAN HEALTH RENSSELAER	151324	23844	1	02/03/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FRANCISCAN HEALTH RENSSELAER	15Z324	99915		12/31/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WHEATFIELD CLINIC	153990	99915		10/07/1999	N	O	N	15.00
15.03	Hospital-Based Health Clinic - RHC IV	BROOK	158502	99915		01/01/2005	N	O	N	15.03
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)	1		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:26 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:26 am

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:26 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1324	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:26 am

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 8/2/2021 9:26 am

		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:	87,490	30,000	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 9:26 am

	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: FRANCISCAN ALLIANCE, INC.	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546-1290	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

		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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 8/2/2021 9:26 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/20/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/13/2021	Y	04/13/2021	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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 9:26 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	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.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		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.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVE	HOWELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927	STEVEN.HOWELL@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1324	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 9:26 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER REIMBURSEMENT		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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 8/2/2021 9:26 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	24,000.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	24,000.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	24,000.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 9:26 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	675	8	1,000			1.00
2.00	HMO and other (see instructions)	141	88				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	896	0	896			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	319			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,571	8	2,215			7.00
8.00	INTENSIVE CARE UNIT	51	6	113			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,622	14	2,328	0.00	172.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	385	731	1,590	0.00	3.53	26.00
26.03	RURAL HEALTH CLINIC IV	1,221	744	2,947	0.00	3.68	26.03
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	179.21	27.00
28.00	Observation Bed Days		158	685			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 8/2/2021 9:26 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	269	4	411	1.00
2.00	HMO and other (see instructions)			42	31		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	269	4	411	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
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: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 8/2/2021 9:26 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			492 S BIERMA ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WHEATFIELD		IN	47978	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	16:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		JASPER				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	16:30	08:00	12:00	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1324
Component CCN: 15-3990

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

Worksheet S-8
Date/Time Prepared:
8/2/2021 9:26 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 8/2/2021 9:26 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1104 E GRACE ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	RENSSELAER		IN	47922	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		JASPER				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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1324
Component CCN: 15-8502

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

Worksheet S-8
Date/Time Prepared:
8/2/2021 9:26 am

RHC IV | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 8/2/2021 9:26 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.391075	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	0	6.00
7.00	Medicaid cost (line 1 times line 6)	0	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)	0	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)	0	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)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	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)	0	0	0	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,070,109	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	426,532	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	656,203	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,413,906	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,173,689	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,173,689	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,173,689	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,624,370	3,624,370	18,698	3,643,068	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	61,543	2,832,480	2,894,023	0	2,894,023	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,311,801	5,765,642	9,077,443	-80,698	8,996,745	5.00
7.00	00700	OPERATION OF PLANT	290,867	1,056,432	1,347,299	0	1,347,299	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,467	32,445	108,912	0	108,912	8.00
9.00	00900	HOUSEKEEPING	361,868	79,567	441,435	-32,158	409,277	9.00
10.00	01000	DIETARY	266,774	153,555	420,329	-239,797	180,532	10.00
11.00	01100	CAFETERIA	0	0	0	239,797	239,797	11.00
13.00	01300	NURSING ADMINISTRATION	236,133	3,191	239,324	0	239,324	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,266	34,853	66,119	0	66,119	14.00
15.00	01500	PHARMACY	277,421	2,537,371	2,814,792	-2,444,427	370,365	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,465,686	471,469	1,937,155	-702	1,936,453	30.00
31.00	03100	INTENSIVE CARE UNIT	466,557	1,222	467,779	0	467,779	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	664,842	384,334	1,049,176	28,590	1,077,766	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	852,269	98,284	950,553	-153	950,400	54.00
60.00	06000	LABORATORY	0	2,028,057	2,028,057	-544	2,027,513	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	26,278	26,278	0	26,278	63.00
65.00	06500	RESPIRATORY THERAPY	571,271	47,898	619,169	0	619,169	65.00
66.00	06600	PHYSICAL THERAPY	732,033	34,525	766,558	-79	766,479	66.00
66.01	06601	WHEATFIELD PT	266,731	3,105	269,836	-146	269,690	66.01
67.00	06700	OCCUPATIONAL THERAPY	131,500	420	131,920	0	131,920	67.00
67.01	06701	WHEATFIELD OT	85,376	4,290	89,666	0	89,666	67.01
68.00	06800	SPEECH PATHOLOGY	94,572	591	95,163	0	95,163	68.00
68.01	06801	WHEATFIELD ST	79,272	593	79,865	0	79,865	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	599,286	599,286	0	599,286	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	181,781	181,781	0	181,781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19	19	2,534,963	2,534,982	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	274,189	57,505	331,694	-15,027	316,667	88.00
88.03	08801	RURAL HEALTH CLINIC IV	294,718	33,985	328,703	-14,266	314,437	88.03
90.00	09000	CLINIC	891,125	192,869	1,083,994	-60	1,083,934	90.00
90.01	09001	WOUND CARE	28,845	119,897	148,742	-454	148,288	90.01
91.00	09100	EMERGENCY	1,006,742	1,349,118	2,355,860	-323	2,355,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,819,868	21,755,432	34,575,300	-6,786	34,568,514	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,506	5,506	0	5,506	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	630,744	38,424	669,168	6,786	675,954	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	0	0	0	0	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	0	0	0	0	0	194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	13,450,612	21,799,362	35,249,974	0	35,249,974	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	404,288	4,047,356		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	243,001	3,137,024		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-925,169	8,071,576		5.00
7.00	00700	OPERATION OF PLANT	0	1,347,299		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	108,912		8.00
9.00	00900	HOUSEKEEPING	-1,347	407,930		9.00
10.00	01000	DIETARY	-18,439	162,093		10.00
11.00	01100	CAFETERIA	-59,890	179,907		11.00
13.00	01300	NURSING ADMINISTRATION	160,725	400,049		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	231,564	297,683		14.00
15.00	01500	PHARMACY	18,225	388,590		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	388,216	388,216		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-825,085	1,111,368		30.00
31.00	03100	INTENSIVE CARE UNIT	0	467,779		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-649,510	428,256		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-24,287	926,113		54.00
60.00	06000	LABORATORY	-6,522	2,020,991		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	26,278		63.00
65.00	06500	RESPIRATORY THERAPY	-653	618,516		65.00
66.00	06600	PHYSICAL THERAPY	0	766,479		66.00
66.01	06601	WHEATFIELD PT	0	269,690		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	131,920		67.00
67.01	06701	WHEATFIELD OT	0	89,666		67.01
68.00	06800	SPEECH PATHOLOGY	0	95,163		68.00
68.01	06801	WHEATFIELD ST	0	79,865		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	599,286		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	181,781		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,534,982		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-52,559	264,108		88.00
88.03	08801	RURAL HEALTH CLINIC IV	-49,417	265,020		88.03
90.00	09000	CLINIC	-150,000	933,934		90.00
90.01	09001	WOUND CARE	-118,900	29,388		90.01
91.00	09100	EMERGENCY	0	2,355,537		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,435,759	33,132,755		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,506		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0		192.01
194.00	07950	ALTERNACARE	0	675,954		194.00
194.01	07951	DME EQUIPMENT	0	0		194.01
194.02	07952	WHEATFIELD FITNESS	0	0		194.02
194.03	07957	JOHNSON FITNESS	0	0		194.03
194.04	07953	FOUNDATION	0	0		194.04
194.05	07954	MEALS ON WHEELS	0	0		194.05
194.06	07955	WATER LAB	0	0		194.06
194.07	07956	ADVERTISING	0	0		194.07
194.08	07958	UNOCCUPIED SPACE	0	0		194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	0		194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,435,759	33,814,215		200.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 9:26 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	152,194	87,603	1.00
	0		152,194	87,603	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	18,698	1.00
	0		0	18,698	
	C - HOUSEKEEPING				
1.00	OPERATING ROOM	50.00	32,158	0	1.00
	0		32,158	0	
	D - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,534,963	1.00
2.00	ALTERNACARE	194.00	0	6,786	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	2,541,749	
500.00	Grand Total: Increases		184,352	2,648,050	500.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 8/2/2021 9:26 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	152,194	87,603	0		1.00
	0		152,194	87,603			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	18,698	12		1.00
	0		0	18,698			
	C - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	32,158	0	0		1.00
	0		32,158	0			
	D - DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,000	0		1.00
2.00	PHARMACY	15.00	0	2,444,427	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	702	0		3.00
4.00	OPERATING ROOM	50.00	0	3,568	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	153	0		5.00
6.00	LABORATORY	60.00	0	544	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	79	0		7.00
8.00	WHEATFIELD PT	66.01	0	146	0		8.00
9.00	RURAL HEALTH CLINIC	88.00	0	15,027	0		9.00
10.00	RURAL HEALTH CLINIC IV	88.03	0	14,266	0		10.00
11.00	CLINIC	90.00	0	60	0		11.00
12.00	WOUND CARE	90.01	0	454	0		12.00
13.00	EMERGENCY	91.00	0	323	0		13.00
	0		0	2,541,749			
500.00	Grand Total: Decreases		184,352	2,648,050			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 8/2/2021 9:26 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	675,791	0	0	0	0	1.00
2.00	Land Improvements	484,426	0	0	0	0	2.00
3.00	Buildings and Fixtures	17,314,748	89,039	0	89,039	0	3.00
4.00	Building Improvements	1,692,153	116,733	0	116,733	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,107,051	829,530	0	829,530	214,523	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,274,169	1,035,302	0	1,035,302	214,523	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,274,169	1,035,302	0	1,035,302	214,523	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	675,791	0	1.00
2.00	Land Improvements	484,426	0	2.00
3.00	Buildings and Fixtures	17,403,787	0	3.00
4.00	Building Improvements	1,808,886	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,722,058	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,094,948	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,094,948	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 8/2/2021 9:26 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,821,514	0	802,856	0	0	1.00
3.00	Total (sum of lines 1-2)	2,821,514	0	802,856	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	3,624,370		1.00
3.00	Total (sum of lines 1-2)	0	3,624,370		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 8/2/2021 9:26 am

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

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,829,953	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,829,953	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	797,551	18,698	0	401,154	4,047,356	1.00
3.00	Total (sum of lines 1-2)	797,551	18,698	0	401,154	4,047,356	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 9:26 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-8,355	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	-1,665,804			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,717,632			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	B	-162	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - 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
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	9	32.00
33.00	HAF OFFSET	A	-1,077,307	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 8/2/2021 9:26 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
39.00	OTHER REVENUE	B	-5,940	RURAL HEALTH CLINIC	88.00	9	39.00
39.01	OTHER REVENUE	B	-55	RURAL HEALTH CLINIC IV	88.03	0	39.01
40.00	OTHER REVENUE	B	-28,836	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	OTHER REVENUE	B	-1,347	HOUSEKEEPING	9.00	0	40.01
40.02	OTHER REVENUE	B	-18,439	DIETARY	10.00	0	40.02
40.03	OTHER REVENUE	B	-59,890	CAFETERIA	11.00	0	40.03
40.04	OTHER REVENUE	B	-41,052	NURSING ADMINISTRATION	13.00	0	40.04
40.05	OTHER REVENUE	B	-4,418	CENTRAL SERVICES & SUPPLY	14.00	0	40.05
40.06	OTHER REVENUE	B	-42,731	PHARMACY	15.00	0	40.06
40.07	OTHER REVENUE	B	-28,872	OPERATING ROOM	50.00	0	40.07
40.08	OTHER REVENUE	B	-8,833	RADIOLOGY-DIAGNOSTIC	54.00	0	40.08
40.09	OTHER REVENUE	B	-6,522	LABORATORY	60.00	0	40.09
40.10	OTHER REVENUE	B	-653	RESPIRATORY THERAPY	65.00	0	40.10
41.00	LOBBYING	A	-734	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ANESTHESIA	A	-60,134	OPERATING ROOM	50.00	0	42.00
43.00	DEPRECIATION CARRY FORWARD	A	8,439	CAP REL COSTS-BLDG & FIXT	1.00	9	43.00
43.01	MARKETING / ADVERTISING	A	-4,203	RADIOLOGY-DIAGNOSTIC	54.00	0	43.01
43.02	MARKETING / ADVERTISING	A	-1,562	ADMINISTRATIVE & GENERAL	5.00	0	43.02
43.03	PHYSICIAN SALARIES	A	-46,619	RURAL HEALTH CLINIC	88.00	0	43.03
43.04	PHYSICIAN SALARIES	A	-49,362	RURAL HEALTH CLINIC IV	88.03	0	43.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,435,759				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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 8/2/2021 9:26 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	401,154	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	3,050	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	4,745,533	5,284,223	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	235,982	0	4.00
4.01	15.00	PHARMACY	CPVP / PHARMACY	41,384	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HIM	388,378	0	4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	799,703	799,703	4.03
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	243,001	0	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	722,024	0	4.05
4.06	13.00	NURSING ADMINISTRATION	SHARED SERVICES	201,777	0	4.06
4.07	15.00	PHARMACY	SHARED SERVICES	19,572	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,801,558	6,083,926	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	B	FRANCISCAN ALLI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 8/2/2021 9:26 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	401,154	14		1.00
2.00	3,050	11		2.00
3.00	-538,690	0		3.00
4.00	235,982	0		4.00
4.01	41,384	0		4.01
4.02	388,378	0		4.02
4.03	0	11		4.03
4.04	243,001	0		4.04
4.05	722,024	0		4.05
4.06	201,777	0		4.06
4.07	19,572	0		4.07
5.00	1,717,632			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 8/2/2021 9:26 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	92,748	64	92,684	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	825,085	825,085	0	0	0	2.00
3.00	50.00	OPERATING ROOM	572,878	560,504	12,374	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	11,251	11,251	0	0	0	4.00
5.00	60.00	LABORATORY	27,000	0	27,000	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	11,375	0	11,375	0	0	6.00
7.00	90.00	CLINIC	150,000	150,000	0	0	0	7.00
8.00	90.01	WOUND CARE	118,900	118,900	0	0	0	8.00
9.00	91.00	EMERGENCY	1,313,104	0	1,313,104	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,122,341	1,665,804	1,456,537		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	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	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.01	WOUND CARE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	64		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	825,085		2.00
3.00	50.00	OPERATING ROOM	0	0	0	560,504		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	11,251		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	90.00	CLINIC	0	0	0	150,000		7.00
8.00	90.01	WOUND CARE	0	0	0	118,900		8.00
9.00	91.00	EMERGENCY	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,665,804		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/2/2021 9:26 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					9	1.00
2.00	Line 1 multiplied by 15 hours per week					135	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					33	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	325.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.91	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)	41.46	41.46	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)					26,946	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)					26,946	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)					26,946	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)					26,946	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)					1,368	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)					1,368	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,368	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)					0	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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/2/2021 9:26 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.91	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)	26,946		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		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)	26,946		63.00
64.00	Total cost of outside supplier services (from your records)	5,719		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	1,368		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,368		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 9:26 am

		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	4,047,356	4,047,356				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,137,024	77,775	3,214,799			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,071,576	407,092	795,187	9,273,855	9,273,855	5.00
7.00	00700	OPERATION OF PLANT	1,347,299	462,210	69,839	1,879,348	710,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,912	49,388	18,360	176,660	66,760	8.00
9.00	00900	HOUSEKEEPING	407,930	55,429	79,165	542,524	205,021	9.00
10.00	01000	DIETARY	162,093	54,740	27,511	244,344	92,338	10.00
11.00	01100	CAFETERIA	179,907	72,736	36,543	289,186	109,284	11.00
13.00	01300	NURSING ADMINISTRATION	400,049	12,488	56,697	469,234	177,324	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	297,683	134,487	7,507	439,677	166,155	14.00
15.00	01500	PHARMACY	388,590	34,271	66,610	489,471	184,972	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	388,216	50,358	0	438,574	165,738	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,111,368	270,133	351,920	1,733,421	655,063	30.00
31.00	03100	INTENSIVE CARE UNIT	467,779	23,567	112,023	603,369	228,014	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	428,256	286,157	167,354	881,767	333,222	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	926,113	162,468	204,635	1,293,216	488,709	54.00
60.00	06000	LABORATORY	2,020,991	88,511	0	2,109,502	797,185	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	26,278	3,192	0	29,470	11,137	63.00
65.00	06500	RESPIRATORY THERAPY	618,516	118,025	137,166	873,707	330,176	65.00
66.00	06600	PHYSICAL THERAPY	766,479	66,539	175,766	1,008,784	381,221	66.00
66.01	06601	WHEATFIELD PT	269,690	295,421	64,044	629,155	237,759	66.01
67.00	06700	OCCUPATIONAL THERAPY	131,920	13,489	31,574	176,983	66,882	67.00
67.01	06701	WHEATFIELD OT	89,666	61,657	20,499	171,822	64,932	67.01
68.00	06800	SPEECH PATHOLOGY	95,163	11,424	22,707	129,294	48,860	68.00
68.01	06801	WHEATFIELD ST	79,865	39,999	19,034	138,898	52,490	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	599,286	0	0	599,286	226,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,781	0	0	181,781	68,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,534,982	0	0	2,534,982	957,975	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	264,108	0	65,834	329,942	124,686	88.00
88.03	08801	RURAL HEALTH CLINIC IV	265,020	80,498	70,764	416,282	157,314	88.03
90.00	09000	CLINIC	933,934	404,557	213,964	1,552,455	586,676	90.00
90.01	09001	WOUND CARE	29,388	30,954	6,926	67,268	25,421	90.01
91.00	09100	EMERGENCY	2,355,537	244,969	241,725	2,842,231	1,074,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,132,755	3,612,534	3,063,354	32,546,488	8,794,779	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,506	8,607	0	14,113	5,333	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	675,954	195,612	151,445	1,023,011	386,598	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	65,600	0	65,600	24,790	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	0	72,048	0	72,048	27,227	194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	92,955	0	92,955	35,128	194.09
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)	33,814,215	4,047,356	3,214,799	33,814,215	9,273,855	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,589,557					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,252	284,672				8.00
9.00	00900	HOUSEKEEPING	46,298	0	793,843			9.00
10.00	01000	DIETARY	45,723	2,462	23,967	408,834		10.00
11.00	01100	CAFETERIA	60,754	0	31,847	0	491,071	11.00
13.00	01300	NURSING ADMINISTRATION	10,431	0	5,468	0	14,293	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	112,333	0	0	0	1,892	14.00
15.00	01500	PHARMACY	28,626	0	15,005	0	16,792	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,063	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	225,632	73,073	118,275	193,410	88,713	30.00
31.00	03100	INTENSIVE CARE UNIT	19,685	25,990	10,319	9,874	28,240	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	239,017	26,385	0	0	42,188	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,704	23,189	71,135	0	51,586	54.00
60.00	06000	LABORATORY	73,930	0	38,753	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,666	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	98,582	2,260	51,676	0	34,578	65.00
66.00	06600	PHYSICAL THERAPY	55,578	23,754	29,134	0	44,308	66.00
66.01	06601	WHEATFIELD PT	246,755	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	11,267	0	5,906	0	7,959	67.00
67.01	06701	WHEATFIELD OT	51,500	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	9,542	0	5,002	0	5,724	68.00
68.01	06801	WHEATFIELD ST	33,410	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	67,237	0	0	0	0	88.03
90.00	09000	CLINIC	337,911	14,379	177,131	0	53,938	90.00
90.01	09001	WOUND CARE	25,855	2,448	13,553	0	1,746	90.01
91.00	09100	EMERGENCY	204,614	33,587	107,257	0	60,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,226,365	227,527	704,428	203,284	452,893	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,189	0	3,768	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	163,388	57,145	85,647	205,550	38,178	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	54,794	0	0	0	0	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	60,179	0	0	0	0	194.08
194.09	07959	LAFAYETTE HHA BRANCH	77,642	0	0	0	0	194.09
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)	2,589,557	284,672	793,843	408,834	491,071	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		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
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	676,750					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	720,057				14.00
15.00	01500	PHARMACY	0	4,147	739,013			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	646,375		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	177,419	3,947	209	34,486	3,303,648	30.00
31.00	03100	INTENSIVE CARE UNIT	76,448	561	0	1,449	1,003,949	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,279	2,004	1,063	22,718	1,604,643	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,312	26,137	46	87,926	2,237,960	54.00
60.00	06000	LABORATORY	0	1,311	162	87,731	3,108,574	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	20,258	0	657	64,188	63.00
65.00	06500	RESPIRATORY THERAPY	0	20,336	0	19,155	1,430,470	65.00
66.00	06600	PHYSICAL THERAPY	0	4,824	24	18,775	1,566,402	66.00
66.01	06601	WHEATFIELD PT	0	1,436	44	11,975	1,127,124	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	8	0	4,546	273,551	67.00
67.01	06701	WHEATFIELD OT	0	108	0	1,685	290,047	67.01
68.00	06800	SPEECH PATHOLOGY	0	224	0	1,702	200,348	68.00
68.01	06801	WHEATFIELD ST	0	46	0	2,741	227,585	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	466,637	0	47,824	1,340,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	140,136	0	12,914	403,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	728,486	203,929	4,425,372	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,592	4,478	1,009	461,707	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	1,327	4,252	1,493	647,905	88.03
90.00	09000	CLINIC	141,332	12,938	18	27,786	2,904,564	90.00
90.01	09001	WOUND CARE	0	419	135	2,132	138,977	90.01
91.00	09100	EMERGENCY	164,960	4,881	96	53,742	4,546,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	676,750	713,277	739,013	646,375	31,307,152	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,225	0	0	34,628	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	0	2,555	0	0	1,962,072	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	0	0	0	145,184	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	0	0	0	0	159,454	194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	0	0	0	205,725	194.09
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	676,750	720,057	739,013	646,375	33,814,215	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,303,648		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,003,949		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,604,643		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,237,960		54.00
60.00	06000	LABORATORY	0	3,108,574		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	64,188		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,430,470		65.00
66.00	06600	PHYSICAL THERAPY	0	1,566,402		66.00
66.01	06601	WHEATFIELD PT	0	1,127,124		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	273,551		67.00
67.01	06701	WHEATFIELD OT	0	290,047		67.01
68.00	06800	SPEECH PATHOLOGY	0	200,348		68.00
68.01	06801	WHEATFIELD ST	0	227,585		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,340,218		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	403,526		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,425,372		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	461,707		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	647,905		88.03
90.00	09000	CLINIC	0	2,904,564		90.00
90.01	09001	WOUND CARE	0	138,977		90.01
91.00	09100	EMERGENCY	0	4,546,394		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	31,307,152		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,628		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0		192.01
194.00	07950	ALTERNACARE	0	1,962,072		194.00
194.01	07951	DME EQUIPMENT	0	0		194.01
194.02	07952	WHEATFIELD FITNESS	0	145,184		194.02
194.03	07957	JOHNSON FITNESS	0	0		194.03
194.04	07953	FOUNDATION	0	0		194.04
194.05	07954	MEALS ON WHEELS	0	0		194.05
194.06	07955	WATER LAB	0	0		194.06
194.07	07956	ADVERTISING	0	0		194.07
194.08	07958	UNOCCUPIED SPACE	0	159,454		194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	205,725		194.09
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	33,814,215		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 9:26 am

		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	77,775	77,775	77,775		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	407,092	407,092	19,235	426,327	5.00
7.00	00700	OPERATION OF PLANT	0	462,210	462,210	1,690	32,648	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,388	49,388	444	3,069	8.00
9.00	00900	HOUSEKEEPING	0	55,429	55,429	1,915	9,425	9.00
10.00	01000	DIETARY	0	54,740	54,740	666	4,245	10.00
11.00	01100	CAFETERIA	0	72,736	72,736	884	5,024	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,488	12,488	1,372	8,152	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	134,487	134,487	182	7,638	14.00
15.00	01500	PHARMACY	0	34,271	34,271	1,612	8,503	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50,358	50,358	0	7,619	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	270,133	270,133	8,514	30,113	30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,567	23,567	2,710	10,482	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	286,157	286,157	4,049	15,318	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	162,468	162,468	4,951	22,466	54.00
60.00	06000	LABORATORY	0	88,511	88,511	0	36,646	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,192	3,192	0	512	63.00
65.00	06500	RESPIRATORY THERAPY	0	118,025	118,025	3,319	15,178	65.00
66.00	06600	PHYSICAL THERAPY	0	66,539	66,539	4,252	17,525	66.00
66.01	06601	WHEATFIELD PT	0	295,421	295,421	1,549	10,930	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	13,489	13,489	764	3,075	67.00
67.01	06701	WHEATFIELD OT	0	61,657	61,657	496	2,985	67.01
68.00	06800	SPEECH PATHOLOGY	0	11,424	11,424	549	2,246	68.00
68.01	06801	WHEATFIELD ST	0	39,999	39,999	460	2,413	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	10,411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,158	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	44,038	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,593	5,732	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	80,498	80,498	1,712	7,232	88.03
90.00	09000	CLINIC	0	404,557	404,557	5,177	26,969	90.00
90.01	09001	WOUND CARE	0	30,954	30,954	168	1,169	90.01
91.00	09100	EMERGENCY	0	244,969	244,969	5,848	49,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,612,534	3,612,534	74,111	404,303	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,607	8,607	0	245	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	0	195,612	195,612	3,664	17,772	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	65,600	65,600	0	1,140	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	0	72,048	72,048	0	1,252	194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	92,955	92,955	0	1,615	194.09
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	4,047,356	4,047,356	77,775	426,327	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	496,548					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,910	60,811				8.00
9.00	00900	HOUSEKEEPING	8,878	0	75,647			9.00
10.00	01000	DIETARY	8,767	526	2,284	71,228		10.00
11.00	01100	CAFETERIA	11,650	0	3,035	0	93,329	11.00
13.00	01300	NURSING ADMINISTRATION	2,000	0	521	0	2,716	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,540	0	0	0	360	14.00
15.00	01500	PHARMACY	5,489	0	1,430	0	3,191	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,066	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,265	15,609	11,271	33,696	16,861	30.00
31.00	03100	INTENSIVE CARE UNIT	3,775	5,552	983	1,720	5,367	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,832	5,636	0	0	8,018	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,021	4,954	6,779	0	9,804	54.00
60.00	06000	LABORATORY	14,176	0	3,693	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	511	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	18,903	483	4,924	0	6,571	65.00
66.00	06600	PHYSICAL THERAPY	10,657	5,074	2,776	0	8,421	66.00
66.01	06601	WHEATFIELD PT	47,315	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,160	0	563	0	1,513	67.00
67.01	06701	WHEATFIELD OT	9,875	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,830	0	477	0	1,088	68.00
68.01	06801	WHEATFIELD ST	6,406	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	12,893	0	0	0	0	88.03
90.00	09000	CLINIC	64,793	3,072	16,879	0	10,251	90.00
90.01	09001	WOUND CARE	4,958	523	1,291	0	332	90.01
91.00	09100	EMERGENCY	39,235	7,175	10,221	0	11,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	426,905	48,604	67,127	35,416	86,074	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,379	0	359	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	31,330	12,207	8,161	35,812	7,255	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	10,507	0	0	0	0	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	11,539	0	0	0	0	194.08
194.09	07959	LAFAYETTE HHA BRANCH	14,888	0	0	0	0	194.09
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)	496,548	60,811	75,647	71,228	93,329	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		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
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	27,249					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	164,207				14.00
15.00	01500	PHARMACY	0	946	55,442			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	66,043		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,143	900	16	3,524	441,045	30.00
31.00	03100	INTENSIVE CARE UNIT	3,078	128	0	148	57,510	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,266	457	80	2,321	370,134	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,429	5,961	3	8,984	254,820	54.00
60.00	06000	LABORATORY	0	299	12	8,964	152,301	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,620	0	67	8,902	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,638	0	1,957	173,998	65.00
66.00	06600	PHYSICAL THERAPY	0	1,100	2	1,918	118,264	66.00
66.01	06601	WHEATFIELD PT	0	328	3	1,224	356,770	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	2	0	465	22,031	67.00
67.01	06701	WHEATFIELD OT	0	25	0	172	75,210	67.01
68.00	06800	SPEECH PATHOLOGY	0	51	0	174	17,839	68.00
68.01	06801	WHEATFIELD ST	0	11	0	280	49,569	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	106,413	0	4,887	121,711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	31,957	0	1,320	36,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	54,653	20,834	119,525	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	363	336	103	8,127	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	303	319	153	103,110	88.03
90.00	09000	CLINIC	5,691	2,950	1	2,839	543,179	90.00
90.01	09001	WOUND CARE	0	95	10	218	39,718	90.01
91.00	09100	EMERGENCY	6,642	1,113	7	5,491	381,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,249	162,660	55,442	66,043	3,451,862	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	964	0	0	11,554	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	0	583	0	0	312,396	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	0	0	0	77,247	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	0	0	0	0	84,839	194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	0	0	0	109,458	194.09
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,249	164,207	55,442	66,043	4,047,356	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	441,045		30.00
31.00	03100	INTENSIVE CARE UNIT	0	57,510		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	370,134		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	254,820		54.00
60.00	06000	LABORATORY	0	152,301		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,902		63.00
65.00	06500	RESPIRATORY THERAPY	0	173,998		65.00
66.00	06600	PHYSICAL THERAPY	0	118,264		66.00
66.01	06601	WHEATFIELD PT	0	356,770		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	22,031		67.00
67.01	06701	WHEATFIELD OT	0	75,210		67.01
68.00	06800	SPEECH PATHOLOGY	0	17,839		68.00
68.01	06801	WHEATFIELD ST	0	49,569		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	121,711		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,435		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	119,525		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	8,127		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	103,110		88.03
90.00	09000	CLINIC	0	543,179		90.00
90.01	09001	WOUND CARE	0	39,718		90.01
91.00	09100	EMERGENCY	0	381,664		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,451,862		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,554		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0		192.01
194.00	07950	ALTERNACARE	0	312,396		194.00
194.01	07951	DME EQUIPMENT	0	0		194.01
194.02	07952	WHEATFIELD FITNESS	0	77,247		194.02
194.03	07957	JOHNSON FITNESS	0	0		194.03
194.04	07953	FOUNDATION	0	0		194.04
194.05	07954	MEALS ON WHEELS	0	0		194.05
194.06	07955	WATER LAB	0	0		194.06
194.07	07956	ADVERTISING	0	0		194.07
194.08	07958	UNOCCUPIED SPACE	0	84,839		194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	109,458		194.09
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,047,356		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	129,317					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,485	13,389,069				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,007	3,311,801	-9,273,855	24,540,360		5.00
7.00	00700	OPERATION OF PLANT	14,768	290,867	0	1,879,348	99,057	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,578	76,467	0	176,660	1,578	8.00
9.00	00900	HOUSEKEEPING	1,771	329,710	0	542,524	1,771	9.00
10.00	01000	DIETARY	1,749	114,580	0	244,344	1,749	10.00
11.00	01100	CAFETERIA	2,324	152,194	0	289,186	2,324	11.00
13.00	01300	NURSING ADMINISTRATION	399	236,133	0	469,234	399	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,297	31,266	0	439,677	4,297	14.00
15.00	01500	PHARMACY	1,095	277,421	0	489,471	1,095	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,609	0	0	438,574	1,609	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,631	1,465,686	0	1,733,421	8,631	30.00
31.00	03100	INTENSIVE CARE UNIT	753	466,557	0	603,369	753	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,143	697,000	0	881,767	9,143	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,191	852,269	0	1,293,216	5,191	54.00
60.00	06000	LABORATORY	2,828	0	0	2,109,502	2,828	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	102	0	0	29,470	102	63.00
65.00	06500	RESPIRATORY THERAPY	3,771	571,271	0	873,707	3,771	65.00
66.00	06600	PHYSICAL THERAPY	2,126	732,033	0	1,008,784	2,126	66.00
66.01	06601	WHEATFIELD PT	9,439	266,731	0	629,155	9,439	66.01
67.00	06700	OCCUPATIONAL THERAPY	431	131,500	0	176,983	431	67.00
67.01	06701	WHEATFIELD OT	1,970	85,376	0	171,822	1,970	67.01
68.00	06800	SPEECH PATHOLOGY	365	94,572	0	129,294	365	68.00
68.01	06801	WHEATFIELD ST	1,278	79,272	0	138,898	1,278	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	599,286	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	181,781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,534,982	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	274,189	0	329,942	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	2,572	294,718	0	416,282	2,572	88.03
90.00	09000	CLINIC	12,926	891,125	0	1,552,455	12,926	90.00
90.01	09001	WOUND CARE	989	28,845	0	67,268	989	90.01
91.00	09100	EMERGENCY	7,827	1,006,742	0	2,842,231	7,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,424	12,758,325	-9,273,855	23,272,633	85,164	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	0	0	14,113	275	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	6,250	630,744	0	1,023,011	6,250	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	2,096	0	0	65,600	2,096	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	2,302	0	0	72,048	2,302	194.08
194.09	07959	LAFAYETTE HHA BRANCH	2,970	0	0	92,955	2,970	194.09
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)	4,047,356	3,214,799		9,273,855	2,589,557	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.297942	0.240106		0.377902	26.142090	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		77,775		426,327	496,548	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005809		0.017372	5.012750	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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	
			8.00	9.00	10.00	11.00	13.00	
		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	142,587					8.00
9.00	00900	HOUSEKEEPING	0	57,930				9.00
10.00	01000	DIETARY	1,233	1,749	21,821			10.00
11.00	01100	CAFETERIA	0	2,324	0	8,113,164		11.00
13.00	01300	NURSING ADMINISTRATION	0	399	0	236,133	4,130,180	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	31,266	0	14.00
15.00	01500	PHARMACY	0	1,095	0	277,421	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,601	8,631	10,323	1,465,686	1,082,791	30.00
31.00	03100	INTENSIVE CARE UNIT	13,018	753	527	466,557	466,557	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,216	0	0	697,000	343,467	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,615	5,191	0	852,269	368,082	54.00
60.00	06000	LABORATORY	0	2,828	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,132	3,771	0	571,271	0	65.00
66.00	06600	PHYSICAL THERAPY	11,898	2,126	0	732,033	0	66.00
66.01	06601	WHEATFIELD PT	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	431	0	131,500	0	67.00
67.01	06701	WHEATFIELD OT	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	365	0	94,572	0	68.00
68.01	06801	WHEATFIELD ST	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	7,202	12,926	0	891,125	862,541	90.00
90.01	09001	WOUND CARE	1,226	989	0	28,845	0	90.01
91.00	09100	EMERGENCY	16,823	7,827	0	1,006,742	1,006,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,964	51,405	10,850	7,482,420	4,130,180	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	275	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
194.00	07950	ALTERNACARE	28,623	6,250	10,971	630,744	0	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	WHEATFIELD FITNESS	0	0	0	0	0	194.02
194.03	07957	JOHNSON FITNESS	0	0	0	0	0	194.03
194.04	07953	FOUNDATION	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	0	0	0	0	0	194.06
194.07	07956	ADVERTISING	0	0	0	0	0	194.07
194.08	07958	UNOCCUPIED SPACE	0	0	0	0	0	194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.09
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)	284,672	793,843	408,834	491,071	676,750	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.996479	13.703487	18.735805	0.060528	0.163855	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	60,811	75,647	71,228	93,329	27,249	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.426483	1.305835	3.264195	0.011503	0.006598	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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 8/2/2021 9:26 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UISITIONS)	PHARMACY (COSTED REQ UISITIONS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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
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	934,043				14.00
15.00	01500	PHARMACY	5,379	2,479,768			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	80,054,188		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,120	702	4,271,206		30.00
31.00	03100	INTENSIVE CARE UNIT	728	0	179,410		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,600	3,568	2,813,691		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,905	153	10,889,978		54.00
60.00	06000	LABORATORY	1,700	544	10,865,841		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	26,278	0	81,354		63.00
65.00	06500	RESPIRATORY THERAPY	26,380	0	2,372,379		65.00
66.00	06600	PHYSICAL THERAPY	6,257	79	2,325,308		66.00
66.01	06601	WHEATFIELD PT	1,863	146	1,483,209		66.01
67.00	06700	OCCUPATIONAL THERAPY	10	0	563,043		67.00
67.01	06701	WHEATFIELD OT	140	0	208,644		67.01
68.00	06800	SPEECH PATHOLOGY	290	0	210,788		68.00
68.01	06801	WHEATFIELD ST	60	0	339,460		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	605,313	0	5,923,176		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,781	0	1,599,446		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,444,446	25,255,819		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,065	15,027	124,977		88.00
88.03	08801	RURAL HEALTH CLINIC IV	1,722	14,266	184,891		88.03
90.00	09000	CLINIC	16,783	60	3,441,360		90.00
90.01	09001	WOUND CARE	543	454	264,087		90.01
91.00	09100	EMERGENCY	6,331	323	6,656,121		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	925,248	2,479,768	80,054,188		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,481	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0		192.01
194.00	07950	ALTERNACARE	3,314	0	0		194.00
194.01	07951	DME EQUIPMENT	0	0	0		194.01
194.02	07952	WHEATFIELD FITNESS	0	0	0		194.02
194.03	07957	JOHNSON FITNESS	0	0	0		194.03
194.04	07953	FOUNDATION	0	0	0		194.04
194.05	07954	MEALS ON WHEELS	0	0	0		194.05
194.06	07955	WATER LAB	0	0	0		194.06
194.07	07956	ADVERTISING	0	0	0		194.07
194.08	07958	UNOCCUPIED SPACE	0	0	0		194.08
194.09	07959	LAFAYETTE HHA BRANCH	0	0	0		194.09
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)	720,057	739,013	646,375		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.770903	0.298017	0.008074		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	164,207	55,442	66,043		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.175802	0.022358	0.000825		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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,303,648		3,303,648	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,003,949		1,003,949	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,604,643		1,604,643	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,237,960		2,237,960	0	0	54.00
60.00	06000	LABORATORY	3,108,574		3,108,574	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,188		64,188	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,430,470	0	1,430,470	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,566,402	0	1,566,402	0	0	66.00
66.01	06601	WHEATFIELD PT	1,127,124	0	1,127,124	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	273,551	0	273,551	0	0	67.00
67.01	06701	WHEATFIELD OT	290,047	0	290,047	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	200,348	0	200,348	0	0	68.00
68.01	06801	WHEATFIELD ST	227,585	0	227,585	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,340,218		1,340,218	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	403,526		403,526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,425,372		4,425,372	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	461,707		461,707	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	647,905		647,905	0	0	88.03
90.00	09000	CLINIC	2,904,564		2,904,564	0	0	90.00
90.01	09001	WOUND CARE	138,977		138,977	0	0	90.01
91.00	09100	EMERGENCY	4,546,394		4,546,394	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	863,669		863,669		0	92.00
200.00		Subtotal (see instructions)	32,170,821	0	32,170,821	0	0	200.00
201.00		Less Observation Beds	863,669		863,669		0	201.00
202.00		Total (see instructions)	31,307,152	0	31,307,152	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,583,206		2,583,206			30.00
31.00	03100	INTENSIVE CARE UNIT	179,410		179,410			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	208,803	2,604,888	2,813,691	0.570298	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	473,501	10,416,477	10,889,978	0.205506	0.000000	54.00
60.00	06000	LABORATORY	1,074,791	9,791,050	10,865,841	0.286087	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	17,709	63,645	81,354	0.788996	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	390,449	1,981,930	2,372,379	0.602969	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	273,201	2,052,107	2,325,308	0.673632	0.000000	66.00
66.01	06601	WHEATFIELD PT	23,787	1,459,422	1,483,209	0.759923	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	277,057	285,986	563,043	0.485844	0.000000	67.00
67.01	06701	WHEATFIELD OT	6,588	202,056	208,644	1.390153	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	28,900	181,888	210,788	0.950472	0.000000	68.00
68.01	06801	WHEATFIELD ST	0	339,460	339,460	0.670432	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	595,982	5,327,194	5,923,176	0.226267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	474,796	1,124,650	1,599,446	0.252291	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,326,845	23,928,974	25,255,819	0.175222	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	124,977	124,977			88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	184,891	184,891			88.03
90.00	09000	CLINIC	26,752	3,414,608	3,441,360	0.844016	0.000000	90.00
90.01	09001	WOUND CARE	0	264,087	264,087	0.526255	0.000000	90.01
91.00	09100	EMERGENCY	253,792	6,402,329	6,656,121	0.683040	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,140	1,654,860	1,688,000	0.511652	0.000000	92.00
200.00		Subtotal (see instructions)	8,248,709	71,805,479	80,054,188			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,248,709	71,805,479	80,054,188			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	WHEATFIELD PT	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	WHEATFIELD OT	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	WHEATFIELD ST	0.000000		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.03	08801	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,303,648		3,303,648	0	3,303,648	30.00
31.00	03100	INTENSIVE CARE UNIT	1,003,949		1,003,949	0	1,003,949	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,604,643		1,604,643	0	1,604,643	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,237,960		2,237,960	0	2,237,960	54.00
60.00	06000	LABORATORY	3,108,574		3,108,574	0	3,108,574	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,188		64,188	0	64,188	63.00
65.00	06500	RESPIRATORY THERAPY	1,430,470	0	1,430,470	0	1,430,470	65.00
66.00	06600	PHYSICAL THERAPY	1,566,402	0	1,566,402	0	1,566,402	66.00
66.01	06601	WHEATFIELD PT	1,127,124	0	1,127,124	0	1,127,124	66.01
67.00	06700	OCCUPATIONAL THERAPY	273,551	0	273,551	0	273,551	67.00
67.01	06701	WHEATFIELD OT	290,047	0	290,047	0	290,047	67.01
68.00	06800	SPEECH PATHOLOGY	200,348	0	200,348	0	200,348	68.00
68.01	06801	WHEATFIELD ST	227,585	0	227,585	0	227,585	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,340,218		1,340,218	0	1,340,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	403,526		403,526	0	403,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,425,372		4,425,372	0	4,425,372	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	461,707		461,707	0	461,707	88.00
88.03	08801	RURAL HEALTH CLINIC IV	647,905		647,905	0	647,905	88.03
90.00	09000	CLINIC	2,904,564		2,904,564	0	2,904,564	90.00
90.01	09001	WOUND CARE	138,977		138,977	0	138,977	90.01
91.00	09100	EMERGENCY	4,546,394		4,546,394	0	4,546,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	863,669		863,669		863,669	92.00
200.00		Subtotal (see instructions)	32,170,821	0	32,170,821	0	32,170,821	200.00
201.00		Less Observation Beds	863,669		863,669		863,669	201.00
202.00		Total (see instructions)	31,307,152	0	31,307,152	0	31,307,152	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,583,206		2,583,206			30.00
31.00	03100	INTENSIVE CARE UNIT	179,410		179,410			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	208,803	2,604,888	2,813,691	0.570298	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	473,501	10,416,477	10,889,978	0.205506	0.000000	54.00
60.00	06000	LABORATORY	1,074,791	9,791,050	10,865,841	0.286087	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	17,709	63,645	81,354	0.788996	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	390,449	1,981,930	2,372,379	0.602969	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	273,201	2,052,107	2,325,308	0.673632	0.000000	66.00
66.01	06601	WHEATFIELD PT	23,787	1,459,422	1,483,209	0.759923	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	277,057	285,986	563,043	0.485844	0.000000	67.00
67.01	06701	WHEATFIELD OT	6,588	202,056	208,644	1.390153	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	28,900	181,888	210,788	0.950472	0.000000	68.00
68.01	06801	WHEATFIELD ST	0	339,460	339,460	0.670432	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	595,982	5,327,194	5,923,176	0.226267	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	474,796	1,124,650	1,599,446	0.252291	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,326,845	23,928,974	25,255,819	0.175222	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	124,977	124,977	3.694336	0.000000	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	184,891	184,891	3.504254	0.000000	88.03
90.00	09000	CLINIC	26,752	3,414,608	3,441,360	0.844016	0.000000	90.00
90.01	09001	WOUND CARE	0	264,087	264,087	0.526255	0.000000	90.01
91.00	09100	EMERGENCY	253,792	6,402,329	6,656,121	0.683040	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,140	1,654,860	1,688,000	0.511652	0.000000	92.00
200.00		Subtotal (see instructions)	8,248,709	71,805,479	80,054,188			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,248,709	71,805,479	80,054,188			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	WHEATFIELD PT	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	WHEATFIELD OT	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	WHEATFIELD ST	0.000000		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	370,134	2,813,691	0.131547	126,402	16,628	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,820	10,889,978	0.023399	209,088	4,892	54.00
60.00	06000	LABORATORY	152,301	10,865,841	0.014016	543,166	7,613	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,902	81,354	0.109423	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	173,998	2,372,379	0.073343	175,395	12,864	65.00
66.00	06600	PHYSICAL THERAPY	118,264	2,325,308	0.050859	30,845	1,569	66.00
66.01	06601	WHEATFIELD PT	356,770	1,483,209	0.240539	4,096	985	66.01
67.00	06700	OCCUPATIONAL THERAPY	22,031	563,043	0.039128	23,787	931	67.00
67.01	06701	WHEATFIELD OT	75,210	208,644	0.360470	3,679	1,326	67.01
68.00	06800	SPEECH PATHOLOGY	17,839	210,788	0.084630	6,588	558	68.00
68.01	06801	WHEATFIELD ST	49,569	339,460	0.146023	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,711	5,923,176	0.020548	270,829	5,565	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,435	1,599,446	0.022780	374,879	8,540	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,525	25,255,819	0.004733	573,932	2,716	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,127	124,977	0.065028	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	103,110	184,891	0.557680	0	0	88.03
90.00	09000	CLINIC	543,179	3,441,360	0.157838	16,269	2,568	90.00
90.01	09001	WOUND CARE	39,718	264,087	0.150397	0	0	90.01
91.00	09100	EMERGENCY	381,664	6,656,121	0.057340	94,334	5,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	115,302	1,688,000	0.068307	7,696	526	92.00
200.00		Total (lines 50 through 199)	3,068,609	77,291,572		2,460,985	72,690	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	WHEATFIELD PT	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	WHEATFIELD OT	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	WHEATFIELD ST	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,813,691	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,889,978	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,865,841	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	81,354	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,372,379	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,325,308	0.000000	66.00
66.01	06601	WHEATFIELD PT	0	0	0	1,483,209	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	563,043	0.000000	67.00
67.01	06701	WHEATFIELD OT	0	0	0	208,644	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	210,788	0.000000	68.00
68.01	06801	WHEATFIELD ST	0	0	0	339,460	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,923,176	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,599,446	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,255,819	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	124,977	0.000000	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	184,891	0.000000	88.03
90.00	09000	CLINIC	0	0	0	3,441,360	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	264,087	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	6,656,121	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,688,000	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	77,291,572		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	126,402	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	209,088	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	543,166	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	175,395	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	30,845	0	0	0	66.00
66.01	06601	WHEATFIELD PT	0.000000	4,096	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	23,787	0	0	0	67.00
67.01	06701	WHEATFIELD OT	0.000000	3,679	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	6,588	0	0	0	68.00
68.01	06801	WHEATFIELD ST	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	270,829	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	374,879	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	573,932	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	16,269	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	94,334	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	7,696	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,460,985	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.570298	0	730,062	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205506	0	3,559,164	0	0	54.00
60.00	06000	LABORATORY	0.286087	0	1,543,670	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.788996	0	34,860	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.602969	0	859,310	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.673632	0	1,348,972	0	0	66.00
66.01	06601	WHEATFIELD PT	0.759923	0	15,994	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.485844	0	89,654	0	0	67.00
67.01	06701	WHEATFIELD OT	1.390153	0	707	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.950472	0	33,256	0	0	68.00
68.01	06801	WHEATFIELD ST	0.670432	0	191	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.226267	0	1,366,860	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.252291	0	364,621	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175222	0	11,708,573	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.03	08801	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.844016	0	1,482,521	0	0	90.00
90.01	09001	WOUND CARE	0.526255	0	67,975	0	0	90.01
91.00	09100	EMERGENCY	0.683040	0	1,863,393	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.511652	0	928,319	0	0	92.00
200.00		Subtotal (see instructions)		0	25,998,102	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	25,998,102	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	416,353	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	731,430	0		54.00
60.00	06000	LABORATORY	441,624	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	27,504	0		63.00
65.00	06500	RESPIRATORY THERAPY	518,137	0		65.00
66.00	06600	PHYSICAL THERAPY	908,711	0		66.00
66.01	06601	WHEATFIELD PT	12,154	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	43,558	0		67.00
67.01	06701	WHEATFIELD OT	983	0		67.01
68.00	06800	SPEECH PATHOLOGY	31,609	0		68.00
68.01	06801	WHEATFIELD ST	128	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	309,275	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	91,991	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,051,600	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.03	08801	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	1,251,271	0		90.00
90.01	09001	WOUND CARE	35,772	0		90.01
91.00	09100	EMERGENCY	1,272,772	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	474,976	0		92.00
200.00		Subtotal (see instructions)	8,619,848	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,619,848	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | 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	0.570298	0	0	417,548	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205506	0	0	1,580,446	0	54.00
60.00	06000	LABORATORY	0.286087	0	0	1,503,809	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.788996	0	0	7,427	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.602969	0	0	263,482	0	65.00
66.00	06600	PHYSICAL THERAPY	0.673632	0	0	439,797	0	66.00
66.01	06601	WHEATFIELD PT	0.759923	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.485844	0	0	0	0	67.00
67.01	06701	WHEATFIELD OT	1.390153	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.950472	0	0	68,459	0	68.00
68.01	06801	WHEATFIELD ST	0.670432	0	0	2,324	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.226267	0	0	738,459	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.252291	0	0	208,407	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175222	0	0	1,214,525	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.03	08801	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.844016	0	0	313,493	0	90.00
90.01	09001	WOUND CARE	0.526255	0	0	50,329	0	90.01
91.00	09100	EMERGENCY	0.683040	0	0	1,318,614	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.511652	0	0	248,160	0	92.00
200.00		Subtotal (see instructions)		0	0	8,375,279	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	8,375,279	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | 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	0	238,127		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	324,791		54.00
60.00	06000	LABORATORY	0	430,220		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	5,860		63.00
65.00	06500	RESPIRATORY THERAPY	0	158,871		65.00
66.00	06600	PHYSICAL THERAPY	0	296,261		66.00
66.01	06601	WHEATFIELD PT	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	WHEATFIELD OT	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	65,068		68.00
68.01	06801	WHEATFIELD ST	0	1,558		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	167,089		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,579		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	212,811		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.03	08801	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	0	264,593		90.00
90.01	09001	WOUND CARE	0	26,486		90.01
91.00	09100	EMERGENCY	0	900,666		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	126,972		92.00
200.00		Subtotal (see instructions)	0	3,271,952		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	3,271,952		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,900	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,685	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,000	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	896	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	319	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)	675	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)	896	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	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,303,648	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)	49,451	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,179,155	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,124,493	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)	2,124,493	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)	1,260.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	851,060	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)	851,060	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,003,949	113	8,884.50	51	453,110	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)	761,559	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,065,729	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,129,704	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,129,704	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)	685	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,260.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	863,669	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	441,045	3,303,648	0.133502	863,669	115,302	90.00
91.00	Nursing School cost	0	3,303,648	0.000000	863,669	0	91.00
92.00	Allied health cost	0	3,303,648	0.000000	863,669	0	92.00
93.00	All other Medical Education	0	3,303,648	0.000000	863,669	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,900	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,685	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,000	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	896	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	319	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)	8	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)	896	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)	3,303,648	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)	1,146,871	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,156,777	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)	2,156,777	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)	1,279.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	10,240	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)	10,240	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,003,949	113	8,884.50	6	53,307	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)	139,362	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	202,909	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,146,871	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,146,871	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)	685	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,279.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	876,793	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	441,045	3,303,648	0.133502	876,793	117,054	90.00
91.00	Nursing School cost	0	3,303,648	0.000000	876,793	0	91.00
92.00	Allied health cost	0	3,303,648	0.000000	876,793	0	92.00
93.00	All other Medical Education	0	3,303,648	0.000000	876,793	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		817,613		30.00
31.00	03100	INTENSIVE CARE UNIT		96,216		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.570298	126,402	72,087	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205506	209,088	42,969	54.00
60.00	06000	LABORATORY	0.286087	543,166	155,393	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.788996	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.602969	175,395	105,758	65.00
66.00	06600	PHYSICAL THERAPY	0.673632	30,845	20,778	66.00
66.01	06601	WHEATFIELD PT	0.759923	4,096	3,113	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.485844	23,787	11,557	67.00
67.01	06701	WHEATFIELD OT	1.390153	3,679	5,114	67.01
68.00	06800	SPEECH PATHOLOGY	0.950472	6,588	6,262	68.00
68.01	06801	WHEATFIELD ST	0.670432	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.226267	270,829	61,280	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.252291	374,879	94,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175222	573,932	100,566	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.844016	16,269	13,731	90.00
90.01	09001	WOUND CARE	0.526255	0	0	90.01
91.00	09100	EMERGENCY	0.683040	94,334	64,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.511652	7,696	3,938	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,460,985	761,559	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)		2,460,985		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.570298	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205506	11,480	2,359	54.00
60.00	06000	LABORATORY	0.286087	98,205	28,095	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.788996	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.602969	68,787	41,476	65.00
66.00	06600	PHYSICAL THERAPY	0.673632	166,448	112,125	66.00
66.01	06601	WHEATFIELD PT	0.759923	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.485844	179,504	87,211	67.00
67.01	06701	WHEATFIELD OT	1.390153	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.950472	9,411	8,945	68.00
68.01	06801	WHEATFIELD ST	0.670432	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.226267	61,829	13,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.252291	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175222	155,240	27,201	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.844016	300	253	90.00
90.01	09001	WOUND CARE	0.526255	0	0	90.01
91.00	09100	EMERGENCY	0.683040	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.511652	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		751,204	321,655	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)		751,204		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		87,929		30.00
31.00	03100	INTENSIVE CARE UNIT		23,559		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.570298	12,584	7,177	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205506	65,654	13,492	54.00
60.00	06000	LABORATORY	0.286087	95,633	27,359	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.788996	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.602969	21,784	13,135	65.00
66.00	06600	PHYSICAL THERAPY	0.673632	5,620	3,786	66.00
66.01	06601	WHEATFIELD PT	0.759923	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.485844	0	0	67.00
67.01	06701	WHEATFIELD OT	1.390153	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.950472	274	260	68.00
68.01	06801	WHEATFIELD ST	0.670432	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.226267	35,116	7,946	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.252291	12,993	3,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175222	131,201	22,989	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3.694336	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	3.504254	0	0	88.03
90.00	09000	CLINIC	0.844016	113	95	90.00
90.01	09001	WOUND CARE	0.526255	0	0	90.01
91.00	09100	EMERGENCY	0.683040	51,645	35,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.511652	8,929	4,569	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		441,546	139,362	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)		441,546		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 9:26 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,619,848	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)	8,619,848	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)	8,706,046	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	80,416	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,866,366	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,759,264	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,759,264	30.00
31.00	Primary payer payments	38,557	31.00
32.00	Subtotal (line 30 minus line 31)	3,720,707	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)	610,560	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	396,864	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	366,045	36.00
37.00	Subtotal (see instructions)	4,117,571	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)	4,117,571	40.00
40.01	Sequestration adjustment (see instructions)	27,176	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	5,342,332	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)	-1,251,937	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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,975,055		5,342,332	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)		1,975,055		5,342,332	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		156,555		1,251,937	6.02
7.00	Total Medicare program liability (see instructions)		1,818,500		4,090,395	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: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,744,734		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)		1,744,734		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		313,538		0	6.02
7.00	Total Medicare program liability (see instructions)		1,431,196		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: 15-1324	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 9:26 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 8/2/2021 9:26 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,141,001	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)	324,872	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	896	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,465,873	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,465,873	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,465,873	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	25,168	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,440,705	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,440,705	0	19.00
19.01	Sequestration adjustment (see instructions)	9,509	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	1,744,734	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)	-313,538	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: 15-1324	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 8/2/2021 9:26 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,065,729	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)	2,065,729	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,086,386	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)	2,086,386	19.00
20.00	Deductibles (exclude professional component)	277,376	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,809,010	22.00
23.00	Coinsurance	8,096	23.00
24.00	Subtotal (line 22 minus line 23)	1,800,914	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45,643	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	29,668	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,058	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,830,582	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)	1,830,582	30.00
30.01	Sequestration adjustment (see instructions)	12,082	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,975,055	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)	-156,555	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 9:26 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	202,909		1.00
2.00	Medical and other services		3,271,952	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	202,909	3,271,952	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	202,909	3,271,952	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	441,546	8,375,279	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	441,546	8,375,279	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	441,546	8,375,279	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	238,637	5,103,327	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	202,909	3,271,952	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	202,909	3,271,952	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	202,909	3,271,952	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	202,909	3,271,952	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	202,909	3,271,952	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	202,909	3,271,952	40.00
41.00	Interim payments	204,150	3,253,843	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-1,241	18,109	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 8/2/2021 9:26 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	19,835	0	0	0	1.00
2.00	Temporary investments	733,522	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,710,278	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,339,113	0	0	0	6.00
7.00	Inventory	893,459	0	0	0	7.00
8.00	Prepaid expenses	392,806	0	0	0	8.00
9.00	Other current assets	83,413	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)	6,494,200	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	675,791	0	0	0	12.00
13.00	Land improvements	484,426	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,162,169	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,772,561	0	0	0	23.00
24.00	Accumulated depreciation	-13,977,727	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)	19,117,220	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	432,957	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	432,957	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,044,377	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,594,926	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,274,350	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	6,609,589	0	0	0	43.00
44.00	Other current liabilities	14,477,744	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,956,609	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,361,385	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,361,385	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	48,317,994	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-22,273,617				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)	-22,273,617	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,044,377	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 8/2/2021 9:26 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-21,062,415		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,313,503				2.00
3.00	Total (sum of line 1 and line 2)		-22,375,918		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	EQUITY TRANSFERS	196,708		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)		196,708		0		10.00
11.00	Subtotal (line 3 plus line 10)		-22,179,210		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	-1		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)		-1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-22,179,209		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	EQUITY TRANSFERS		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	ROUNDING		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: 15-1324 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/2/2021 9:26 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,584,212		2,584,212	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)	2,584,212		2,584,212	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	179,410		179,410	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)	179,410		179,410	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,763,622		2,763,622	17.00
18.00	Ancillary services	5,142,034	60,397,652	65,539,686	18.00
19.00	Outpatient services	280,544	12,474,978	12,755,522	19.00
20.00	RURAL HEALTH CLINIC	0	111,365	111,365	20.00
20.03	RURAL HEALTH CLINIC IV	0	168,839	168,839	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC AND OTHER REVENUE	465,386	1,272	466,658	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,651,586	73,154,106	81,805,692	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,249,974		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)		35,249,974		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1324	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 8/2/2021 9:26 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,805,692	1.00
2.00	Less contractual allowances and discounts on patients' accounts	50,223,018	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,582,674	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,249,974	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,667,300	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 REVENUE	290,772	24.00
24.01	OTHER NON-OPERATING	159,692	24.01
24.50	COVID-19 PHE Funding	1,903,332	24.50
25.00	Total other income (sum of lines 6-24)	2,353,796	25.00
26.00	Total (line 5 plus line 25)	-1,313,504	26.00
27.00	ROUNDING	-1	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,313,503	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 9:26 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	68,558	13,712	82,270	0	82,270	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	113,250	0	113,250	0	113,250	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	32,495	0	32,495	0	32,495	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	59,886	0	59,886	0	59,886	9.00
10.00	Subtotal (sum of lines 1 through 9)	274,189	13,712	287,901	0	287,901	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	671	671	0	671	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	43,122	43,122	-15,027	28,095	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	43,793	43,793	-15,027	28,766	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	274,189	57,505	331,694	-15,027	316,667	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	274,189	57,505	331,694	-15,027	316,667	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 9:26 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-46,619	35,651		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	113,250		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	32,495		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	59,886		9.00
10.00	Subtotal (sum of lines 1 through 9)	-46,619	241,282		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	671		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	-5,940	22,155		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-5,940	22,826		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-52,559	264,108		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-52,559	264,108		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 9:26 am

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	68,558	13,712	82,270	0	82,270	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	116,621	0	116,621	0	116,621	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	47,365	0	47,365	0	47,365	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	62,174	0	62,174	0	62,174	9.00
10.00	Subtotal (sum of lines 1 through 9)	294,718	13,712	308,430	0	308,430	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	895	895	0	895	15.00
16.00	Transportation (Health Care Staff)	0	423	423	0	423	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	18,955	18,955	-14,266	4,689	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,273	20,273	-14,266	6,007	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	294,718	33,985	328,703	-14,266	314,437	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	294,718	33,985	328,703	-14,266	314,437	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 8/2/2021 9:26 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-49,362	32,908		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	116,621		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	47,365		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	62,174		9.00
10.00	Subtotal (sum of lines 1 through 9)	-49,362	259,068		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	895		15.00
16.00	Transportation (Health Care Staff)	0	423		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	-55	4,634		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-55	5,952		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-49,417	265,020		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-49,417	265,020		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 8/2/2021 9:26 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.06	168	168	10		1.00
2.00	Physician Assistant	0.00	0	10	0		2.00
3.00	Nurse Practitioner	0.98	1,422	1,422	1,394		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.04	1,590		1,404	1,590	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.04	1,590			1,590	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)					264,108	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					264,108	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					197,599	15.00
16.00	Total overhead (sum of lines 14 and 15)					197,599	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					197,599	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					197,599	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					461,707	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 8/2/2021 9:26 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.06	128	128	8		1.00
2.00	Physician Assistant	0.00	0	10	0		2.00
3.00	Nurse Practitioner	0.98	2,819	2,819	2,763		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.04	2,947		2,771	2,947	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.04	2,947			2,947	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)					265,020	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					265,020	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					382,885	15.00
16.00	Total overhead (sum of lines 14 and 15)					382,885	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					382,885	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					382,885	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					647,905	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 8/2/2021 9:26 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			461,707	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			12,963	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			448,744	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,590	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,590	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			282.23	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	282.23	282.23		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	126		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	35,561		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	35,561		16.00
16.01	Total program charges (see instructions)(from contractor's records)		9,856		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,523		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,927		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.)		9,854		16.04
16.05	Total program cost (see instructions)	0	29,781		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,316		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,308		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		29,781		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,684		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		34,465		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		34,465		26.00
26.01	Sequestration adjustment (see instructions)		227		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		16,695		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)		17,543		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: 15-1324 Component CCN: 15-8502	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 8/2/2021 9:26 am
	Title XVIII	RHC IV	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			647,905	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			18,622	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			629,283	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,947	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,947	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			213.53	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00		8.00
9.00	Rate for Program covered visits (see instructions)	213.53	213.53		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	345		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	73,668		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	73,668		16.00
16.01	Total program charges (see instructions)(from contractor's records)		25,896		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,501		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		18,494		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.)		37,455		16.04
16.05	Total program cost (see instructions)	0	55,949		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,355		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,508		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		55,949		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,622		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		68,571		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		68,571		26.00
26.01	Sequestration adjustment (see instructions)		453		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		74,231		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)		-6,113		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: 15-1324 Component CCN: 15-3990	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 8/2/2021 9:26 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	241,282	241,282	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001362	0.005399	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	329	1,303	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,863	2,920	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,192	4,223	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	264,108	264,108	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	197,599	197,599	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.012086	0.015990	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,388	3,160	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,580	7,383	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	29	115	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	192.41	64.20	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	13	34	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,501	2,183	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)		12,963	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)		4,684	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1324 Component CCN: 15-8502	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 8/2/2021 9:26 am
	Title XVIII	RHC IV	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	259,068	259,068	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001412	0.005207	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	366	1,349	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,160	2,742	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,526	4,091	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	265,020	265,020	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	382,885	382,885	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.013305	0.015437	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,094	5,911	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,620	10,002	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	32	118	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	269.38	84.76	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	22	79	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,926	6,696	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)		18,622	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)		12,622	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 9:26 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		16,695	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)		16,695	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		17,543	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		34,238	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: 15-1324 Component CCN: 15-8502	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 8/2/2021 9:26 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		74,231	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)		74,231	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,113	6.02
7.00	Total Medicare program liability (see instructions)		68,118	7.00

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