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: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 6/11/2021 11:56 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/11/2021 Time: 11:56 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 PERRY COUNTY HOSPITAL (15-1322) 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	90,953	58,620	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	191,080	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-49,259		0	10.00
10.01	RURAL HEALTH CLINIC II	0		603		0	10.01
10.02	RURAL HEALTH CLINIC III	0		6,426		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		0		0	10.03
200.00	Total	0	282,033	16,390	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/11/2021 11:56 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8885 SR 237	PO Box: X			1.00
2.00	City: TELL CITY	State: IN	Zip Code: 47586	County: PERRY	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	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PERRY COUNTY HOSPITAL SWING	15Z322	99915		07/01/2004	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	TELL CITY CLINIC	158516	99915		05/18/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PERRY CO FAMILY PRACTICE	158517	99915		05/19/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	TROY CLINIC	158518	99915		11/23/2015	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	CANNELTON CLINIC	158519	99915		05/06/2016	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)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/11/2021 11:56 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.				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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/11/2021 11:56 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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 6/11/2021 11:56 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: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 6/11/2021 11:56 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/11/2021 11:56 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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	269,111	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.01	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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 6/11/2021 11:56 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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 6/11/2021 11:56 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	R		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	04/01/2021	Y	04/01/2021	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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 6/11/2021 11:56 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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINT	BRILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923500	CBRILL@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 6/11/2021 11:56 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/11/2021 11:56 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	25	9,150	48,912.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	48,912.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	48,912.00	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	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/11/2021 11:56 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,147	41	2,038			1.00
2.00	HMO and other (see instructions)	175	214				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	905	0	905			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	232			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,052	41	3,175			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		6	121			13.00
14.00	Total (see instructions)	2,052	47	3,296	0.00	197.38	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	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,264	0	16,880	0.00	25.90	26.00
26.01	RURAL HEALTH CLINIC II	115	0	5,581	0.00	6.56	26.01
26.02	RURAL HEALTH CLINIC III	281	0	1,847	0.00	2.81	26.02
26.03	RURAL HEALTH CLINIC IV	0	0	0	0.00	0.00	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	232.65	27.00
28.00	Observation Bed Days		8	447			28.00
29.00	Ambulance Trips	960					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	1	42			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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 6/11/2021 11:56 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	304	12	616	1.00
2.00	HMO and other (see instructions)			45	58		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	304	12	616	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	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.25	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: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 6/11/2021 11:56 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			109 IN-66		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	TELL CITY		IN	47586	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			06:30	17:00	06:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		PERRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	06:30	17:00	06:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322
Component CCN: 15-8516

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

Worksheet S-8
Date/Time Prepared:
6/11/2021 11:56 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	06:30	16:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 6/11/2021 11:56 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			315 MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	TROY		IN	47588	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		PERRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	10:00	19:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322
Component CCN: 15-8517

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

Worksheet S-8
Date/Time Prepared:
6/11/2021 11:56 am

RHC II | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 6/11/2021 11:56 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			18485 OLD STATE ROAD 37		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LEOPOLD		IN	47551	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	16:00	07:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		PERRY				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	16:00	07:00	11:00	07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322
Component CCN: 15-8518

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

Worksheet S-8

Date/Time Prepared:
6/11/2021 11:56 am

RHC III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	15:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8519 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 6/11/2021 11:56 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street					1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County					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						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County						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						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322
Component CCN: 15-8519

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

Worksheet S-8
Date/Time Prepared:
6/11/2021 11:56 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						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 6/11/2021 11:56 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)	0.372712	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,508,965	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	11,215,609	6.00
7.00	Medicaid cost (line 1 times line 6)	4,180,192	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)	1,671,227	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)	1,671,227	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)	563,124	0	563,124	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	209,883	0	209,883	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)	209,883	0	209,883	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)	2,429,170	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	309,805	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	476,624	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,952,546	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	894,556	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,104,439	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,775,666	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,560,642	2,560,642	110,514	2,671,156	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,144,732	1,144,732	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117,738	2,869,959	2,987,697	225,159	3,212,856	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	995,766	2,610,758	3,606,524	-179,208	3,427,316	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	1,070,658	1,987,740	3,058,398	-9,255	3,049,143	5.02
7.00	00700	OPERATION OF PLANT	246,401	1,331,260	1,577,661	-4,916	1,572,745	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,611	72,611	0	72,611	8.00
9.00	00900	HOUSEKEEPING	277,989	103,269	381,258	0	381,258	9.00
10.00	01000	DIETARY	0	586,754	586,754	-387,109	199,645	10.00
11.00	01100	CAFETERIA	0	0	0	386,684	386,684	11.00
13.00	01300	NURSING ADMINISTRATION	198,191	47,138	245,329	0	245,329	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,036	88,147	246,183	-1,652	244,531	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,577,011	2,267,654	4,844,665	-5,697	4,838,968	30.00
31.00	03100	INTENSIVE CARE UNIT	-5,927	10,773	4,846	-4,846	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	451,218	877,575	1,328,793	-150,396	1,178,397	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	304,688	304,688	0	304,688	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	813,902	260,043	1,073,945	-1,557	1,072,388	54.00
60.00	06000	LABORATORY	744,960	1,206,589	1,951,549	-1,132	1,950,417	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,343	71,271	72,614	0	72,614	62.00
65.00	06500	RESPIRATORY THERAPY	466,025	415,638	881,663	-47,988	833,675	65.00
66.00	06600	PHYSICAL THERAPY	447,628	83,807	531,435	-425	531,010	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,246	13,388	152,634	0	152,634	67.00
68.00	06800	SPEECH PATHOLOGY	65,446	11,438	76,884	0	76,884	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	573,452	573,452	110,417	683,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	103,226	103,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,808	2,130,789	2,208,597	18,461	2,227,058	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,010,285	775,303	2,785,588	-32,732	2,752,856	88.00
88.01	08801	RURAL HEALTH CLINIC II	532,269	292,296	824,565	22	824,587	88.01
88.02	08803	RURAL HEALTH CLINIC III	151,715	62,374	214,089	22,580	236,669	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	3,773	3,773	0	3,773	88.03
90.00	09000	CLINIC	293,901	85,268	379,169	17,478	396,647	90.00
90.01	09001	PAIN MANAGEMENT	0	65,671	65,671	-65,671	0	90.01
90.02	09002	WOUND CARE	210,201	99,387	309,588	46,475	356,063	90.02
90.03	09003	ORTHOPEDIC CLINIC	70,884	41,872	112,756	-34,907	77,849	90.03
91.00	09100	EMERGENCY	745,790	1,583,183	2,328,973	-3,586	2,325,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	802,037	327,724	1,129,761	-23,587	1,106,174	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,144,732	1,144,732	-1,144,732	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,660,521	24,966,966	38,627,487	86,352	38,713,839	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	825,675	298,610	1,124,285	-86,352	1,037,933	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	14,486,196	25,265,576	39,751,772	0	39,751,772	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	2,671,156		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-13,282	1,131,450		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,212,856		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	-1,208,804	2,218,512		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	-83,067	2,966,076		5.02
7.00	00700	OPERATION OF PLANT	-2,015	1,570,730		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,611		8.00
9.00	00900	HOUSEKEEPING	0	381,258		9.00
10.00	01000	DIETARY	-1,272	198,373		10.00
11.00	01100	CAFETERIA	-71,532	315,152		11.00
13.00	01300	NURSING ADMINISTRATION	0	245,329		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,676	241,855		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-319,135	4,519,833		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-618,385	560,012		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-304,688	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,072,388		54.00
60.00	06000	LABORATORY	0	1,950,417		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	72,614		62.00
65.00	06500	RESPIRATORY THERAPY	-267,638	566,037		65.00
66.00	06600	PHYSICAL THERAPY	0	531,010		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	152,634		67.00
68.00	06800	SPEECH PATHOLOGY	0	76,884		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	683,869		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	103,226		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,950	2,225,108		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-238	2,752,618		88.00
88.01	08801	RURAL HEALTH CLINIC II	-60	824,527		88.01
88.02	08803	RURAL HEALTH CLINIC III	0	236,669		88.02
88.03	08802	RURAL HEALTH CLINIC IV	-3,773	0		88.03
90.00	09000	CLINIC	-26,250	370,397		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
90.02	09002	WOUND CARE	-70,909	285,154		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	77,849		90.03
91.00	09100	EMERGENCY	0	2,325,387		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,448	1,104,726		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,997,122	35,716,717		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,037,933		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,997,122	36,754,650		200.00

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/11/2021 11:56 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COST				
1.00	CAFETERIA	11.00	0	386,684	1.00
	0		0	386,684	
	B - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,144,732	1.00
	0		0	1,144,732	
	C - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	72,904	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	72,904	
	D - INSURANCE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	37,610	1.00
2.00		0.00	0	0	2.00
	0		0	37,610	
	E - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	37,682	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	37,682	
	F - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	213,643	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	213,643	
	G - IMPLANTABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	103,226	1.00
	0		0	103,226	
	H - WOUND CARE RECLASS				
1.00	WOUND CARE	90.02	71,297	0	1.00
2.00		0.00	0	0	2.00
	0		71,297	0	
	I - RHC RECRUITING EXPENSE RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	0	9,058	1.00
	0		0	9,058	
	J - IV THERAPY				
1.00	CLINIC	90.00	0	18,518	1.00
	0		0	18,518	
	K - SURGEON RECLASS				
1.00	OPERATING ROOM	50.00	20,815	0	1.00
	0		20,815	0	
	L - TELL CITY RECLASS				
1.00	RURAL HEALTH CLINIC II	88.01	2,088	0	1.00
2.00	RURAL HEALTH CLINIC III	88.02	24,646	0	2.00
	0		26,734	0	
	M - ICU RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	10,294	1.00
2.00	INTENSIVE CARE UNIT	31.00	5,927	0	2.00
	0		5,927	10,294	

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/11/2021 11:56 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	N - PAIN MGMT					
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	65,671		1.00
	TOTALS		0	65,671		
	O - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	225,584		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	225,584		
500.00	Grand Total: Increases		124,773	2,325,606		500.00

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/11/2021 11:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COST						
1.00	DIETARY	10.00	0	386,684	0		1.00
	0		0	386,684			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,144,732	11		1.00
	0		0	1,144,732			
	C - LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	425	9		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	2,598	0		2.00
3.00	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	9,255	0		3.00
4.00	OPERATION OF PLANT	7.00	0	4,916	0		4.00
5.00	DIETARY	10.00	0	425	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,652	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	8,407	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	479	0		8.00
9.00	OPERATING ROOM	50.00	0	14,457	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,557	0		10.00
11.00	LABORATORY	60.00	0	1,132	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	18,301	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	425	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	425	0		14.00
15.00	CLINIC	90.00	0	1,035	0		15.00
16.00	WOUND CARE	90.02	0	425	0		16.00
17.00	EMERGENCY	91.00	0	1,819	0		17.00
18.00	AMBULANCE SERVICES	95.00	0	5,171	0		18.00
	0		0	72,904			
	D - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	19,194	10		1.00
2.00	AMBULANCE SERVICES	95.00	0	18,416	0		2.00
	0		0	37,610			
	E - DRUGS CHARGED						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	1,873	0		1.00
2.00	WOUND CARE	90.02	0	902	0		2.00
3.00	ORTHOPEDIC CLINIC	90.03	0	34,907	0		3.00
	0		0	37,682			
	F - BILLABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	1,657	0		1.00
2.00	OPERATING ROOM	50.00	0	156,754	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	29,687	0		3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0	278	0		4.00
5.00	CLINIC	90.00	0	5	0		5.00
6.00	WOUND CARE	90.02	0	23,495	0		6.00
7.00	EMERGENCY	91.00	0	1,767	0		7.00
	0		0	213,643			
	G - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	103,226	0		1.00
	0		0	103,226			
	H - WOUND CARE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	17,250	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	54,047	0	0		2.00
	0		71,297	0			
	I - RHC RECRUITING EXPENSE RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	9,058	0		1.00
	0		0	9,058			
	J - IV THERAPY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	18,518	0		1.00
	0		0	18,518			
	K - SURGEON RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	20,815	0	0		1.00
	0		20,815	0			
	L - TELL CITY RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	18,343	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	8,391	0	0		2.00
	0		26,734	0			
	M - ICU RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	5,927	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	10,294	0		2.00
	0		5,927	10,294			
	N - PAIN MGMT						
1.00	PAIN MANAGEMENT	90.01	0	65,671	0		1.00
	TOTALS		0	65,671			

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 6/11/2021 11:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	O - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	212,156	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	6,197	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	2,066	0		3.00
4.00	RURAL HEALTH CLINIC III	88.02	0	2,066	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,099	0		5.00
	TOTALS		0	225,584			
500.00	Grand Total: Decreases		124,773	2,325,606			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I Date/Time Prepared: 6/11/2021 11:56 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	3,815,753	0	0	0	0	1.00
2.00	Land Improvements	66,330	0	0	0	6,973	2.00
3.00	Buildings and Fixtures	44,023,461	47,315	0	47,315	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,330,717	87,872	0	87,872	0	5.00
6.00	Movable Equipment	16,721,887	1,000,448	0	1,000,448	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,958,148	1,135,635	0	1,135,635	6,973	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	66,958,148	1,135,635	0	1,135,635	6,973	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,815,753	0	1.00
2.00	Land Improvements	59,357	0	2.00
3.00	Buildings and Fixtures	44,070,776	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,418,589	0	5.00
6.00	Movable Equipment	17,722,335	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,086,810	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	68,086,810	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 6/11/2021 11:56 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,467,746	0	0	89,688	3,208	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,467,746	0	0	89,688	3,208	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,560,642		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,560,642		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 6/11/2021 11:56 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	50,364,475	0	50,364,475	0.739710	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	17,722,335	0	17,722,335	0.260290	0	2.00
3.00	Total (sum of lines 1-2)	68,086,810	0	68,086,810	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,540,650	37,610	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	-13,282	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,540,650	24,328	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	89,688	3,208	0	2,671,156	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,144,732	0	0	0	1,131,450	2.00
3.00	Total (sum of lines 1-2)	1,144,732	89,688	3,208	0	3,802,606	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 6/11/2021 11:56 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-78,632	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	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)	A	-9,820	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,015	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,606,653			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	65,350			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-71,532	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-60,038	ADMINISTRATIVE AND GENERAL	5.01	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,950	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,676	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,272	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** 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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 6/11/2021 11:56 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADMINISTRATION MISCELLANEOUS REVENUE	B	-125,275	ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	AMBULANCE MISC REVENUE	B	-1,448	AMBULANCE SERVICES	95.00	0	33.01
33.02	ADMINISTRATION-CONTRIBUTIONS	A	-8,655	ADMINISTRATIVE AND GENERAL	5.01	0	33.02
33.03	ADMINISTRATION-MISC EXPENSES	A	-73,247	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	33.03
33.04	ADVERTISING - TELL CITY	A	-238	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	ADVERTISING - PCM	A	-60	RURAL HEALTH CLINIC II	88.01	0	33.05
33.06	WOUND CENTER-ADVERTISING	A	-352	WOUND CARE	90.02	0	33.06
33.07	ADMINISTRATION-RECRUITING	A	-169,339	ADMINISTRATIVE AND GENERAL	5.01	0	33.07
33.08	HAF FEES	B	-840,997	ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	LOBBYING DUES	A	-4,500	ADMINISTRATIVE AND GENERAL	5.01	0	33.09
33.10	CANNELTON OFFSET	A	-3,773	RURAL HEALTH CLINIC IV	88.03	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,997,122				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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 6/11/2021 11:56 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	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65,350	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			65,350	0	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	PERRY CO AMBULA	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:	OTHER				100.00

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.

(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: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 6/11/2021 11:56 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	65,350	10		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	65,350			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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 6/11/2021 11:56 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	30.00	ADULTS & PEDIATRICS	1,124,024	319,135	804,889	0	0	1.00
2.00	50.00	OPERATING ROOM	618,385	618,385	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	304,688	304,688	0	0	0	3.00
4.00	60.00	LABORATORY	16,500	0	16,500	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	267,638	267,638	0	0	0	5.00
6.00	90.00	CLINIC	26,250	26,250	0	0	0	6.00
7.00	90.02	WOUND CARE	70,557	70,557	0	0	0	7.00
8.00	91.00	EMERGENCY	1,376,669	0	1,376,669	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,804,711	1,606,653	2,198,058		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.02	WOUND CARE	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	319,135		1.00
2.00	50.00	OPERATING ROOM	0	0	0	618,385		2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	304,688		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	267,638		5.00
6.00	90.00	CLINIC	0	0	0	26,250		6.00
7.00	90.02	WOUND CARE	0	0	0	70,557		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,606,653		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,671,156	2,671,156				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,131,450		1,131,450			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,212,856	12,716	5,386	3,230,958		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,218,512	205,700	87,131	237,150	2,748,493	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	2,966,076	169,972	71,997	254,986	3,463,031	5.02
7.00	00700	OPERATION OF PLANT	1,570,730	515,661	218,422	58,682	2,363,495	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,611	4,400	1,864	0	78,875	8.00
9.00	00900	HOUSEKEEPING	381,258	29,590	12,534	66,205	489,587	9.00
10.00	01000	DIETARY	198,373	112,244	47,544	0	358,161	10.00
11.00	01100	CAFETERIA	315,152	0	0	0	315,152	11.00
13.00	01300	NURSING ADMINISTRATION	245,329	5,940	2,516	47,201	300,986	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,855	33,000	13,978	37,638	326,471	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,519,833	390,985	165,614	612,329	5,688,761	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	15,972	6,765	0	22,737	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	560,012	287,386	121,731	112,418	1,081,547	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,510	29,867	0	100,377	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,072,388	145,464	61,616	193,837	1,473,305	54.00
60.00	06000	LABORATORY	1,950,417	60,104	25,459	177,418	2,213,398	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	72,614	0	0	320	72,934	62.00
65.00	06500	RESPIRATORY THERAPY	566,037	90,376	38,282	110,988	805,683	65.00
66.00	06600	PHYSICAL THERAPY	531,010	44,440	18,824	106,606	700,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	152,634	19,294	8,173	33,163	213,264	67.00
68.00	06800	SPEECH PATHOLOGY	76,884	10,142	4,296	15,586	106,908	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	683,869	0	0	0	683,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	103,226	0	0	0	103,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,225,108	33,154	14,043	18,531	2,290,836	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,752,618	0	0	474,397	3,227,015	88.00
88.01	08801	RURAL HEALTH CLINIC II	824,527	0	0	127,261	951,788	88.01
88.02	08803	RURAL HEALTH CLINIC III	236,669	0	0	42,002	278,671	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	370,397	98,890	41,888	69,995	581,170	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	285,154	34,804	14,742	67,041	401,741	90.02
90.03	09003	ORTHOPEDIC CLINIC	77,849	0	0	16,882	94,731	90.03
91.00	09100	EMERGENCY	2,325,387	150,854	63,899	177,616	2,717,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,104,726	99,000	41,935	0	1,245,661	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,716,717	2,640,598	1,118,506	3,058,252	35,500,509	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,558	12,944	0	43,502	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,037,933	0	0	172,706	1,210,639	192.00
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)	36,754,650	2,671,156	1,131,450	3,230,958	36,754,650	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,748,493					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	279,893	3,742,924	3,742,924			5.02
7.00	00700	OPERATION OF PLANT	191,025	2,554,520	301,589	2,856,109		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,375	85,250	10,065	7,112	102,427	8.00
9.00	00900	HOUSEKEEPING	39,570	529,157	62,473	47,825	19,332	9.00
10.00	01000	DIETARY	28,948	387,109	45,702	181,416	0	10.00
11.00	01100	CAFETERIA	25,472	340,624	40,214	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	24,327	325,313	38,407	9,601	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,386	352,857	41,659	53,337	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	459,795	6,148,556	725,913	631,932	30,938	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,838	24,575	2,901	25,815	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87,414	1,168,961	138,009	464,492	7,215	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,113	108,490	12,808	113,963	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,077	1,592,382	187,998	235,108	9,915	54.00
60.00	06000	LABORATORY	178,893	2,392,291	282,436	97,144	827	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,895	78,829	9,307	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	65,118	870,801	102,808	146,071	876	65.00
66.00	06600	PHYSICAL THERAPY	56,647	757,527	89,434	71,827	2,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,237	230,501	27,213	31,184	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,641	115,549	13,642	16,392	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,272	739,141	87,264	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,343	111,569	13,172	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185,152	2,475,988	292,318	53,586	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	260,817	3,487,832	411,777	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	76,926	1,028,714	121,451	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	22,523	301,194	35,559	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	46,972	628,142	74,159	159,832	3,516	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	32,470	434,211	51,263	56,252	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	7,656	102,387	12,088	0	0	90.03
91.00	09100	EMERGENCY	219,657	2,937,413	346,794	243,820	27,350	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	100,678	1,346,339	158,950	160,010	292	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,647,130	35,399,146	3,737,373	2,806,719	102,427	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,516	47,018	5,551	49,390	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	97,847	1,308,486	0	0	0	192.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,748,493	36,754,650	3,742,924	2,856,109	102,427	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	658,787					9.00
10.00	01000	DIETARY	42,666	656,893				10.00
11.00	01100	CAFETERIA	0	0	380,838			11.00
13.00	01300	NURSING ADMINISTRATION	2,258	0	10,120	385,699		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,544	0	12,401	0	472,798	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	148,620	656,893	107,532	218,319	135,303	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	6,071	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	109,240	0	21,043	42,712	6,081	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,802	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,293	0	41,958	0	19,763	54.00
60.00	06000	LABORATORY	22,847	0	50,440	0	30,405	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	34,353	0	26,473	0	24,324	65.00
66.00	06600	PHYSICAL THERAPY	16,892	0	20,337	0	6,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,334	0	6,843	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,855	0	2,474	0	6,081	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,602	0	7,357	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	37,590	0	20,529	41,690	135,302	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	13,230	0	12,465	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	57,342	0	40,866	82,978	92,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	37,632	0	0	0	16,723	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	647,171	656,893	380,838	385,699	472,798	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,616	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	658,787	656,893	380,838	385,699	472,798	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	ADMINISTRATIVE AND GENERAL					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,804,006	0	8,804,006		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	59,362	0	59,362		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,957,753	0	1,957,753		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,063	0	262,063		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,142,417	0	2,142,417		54.00
60.00	06000	LABORATORY	2,876,390	0	2,876,390		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88,136	0	88,136		62.00
65.00	06500	RESPIRATORY THERAPY	1,205,706	0	1,205,706		65.00
66.00	06600	PHYSICAL THERAPY	964,264	0	964,264		66.00
67.00	06700	OCCUPATIONAL THERAPY	303,075	0	303,075		67.00
68.00	06800	SPEECH PATHOLOGY	157,993	0	157,993		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	826,405	0	826,405		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,741	0	124,741		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,841,851	0	2,841,851		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,899,609	0	3,899,609		88.00
88.01	08801	RURAL HEALTH CLINIC II	1,150,165	0	1,150,165		88.01
88.02	08803	RURAL HEALTH CLINIC III	336,753	0	336,753		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0		88.03
90.00	09000	CLINIC	1,100,760	0	1,100,760		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0		90.01
90.02	09002	WOUND CARE	567,421	0	567,421		90.02
90.03	09003	ORTHOPEDIC CLINIC	114,475	0	114,475		90.03
91.00	09100	EMERGENCY	3,829,298	0	3,829,298		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,719,946	0	1,719,946		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,332,589	0	35,332,589		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	113,575	0	113,575		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,308,486	0	1,308,486		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	36,754,650	0	36,754,650		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,716	5,386	18,102	18,102	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	0	205,700	87,131	292,831	1,328	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	0	169,972	71,997	241,969	1,428	5.02
7.00	00700	OPERATION OF PLANT	0	515,661	218,422	734,083	329	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,400	1,864	6,264	0	8.00
9.00	00900	HOUSEKEEPING	0	29,590	12,534	42,124	371	9.00
10.00	01000	DIETARY	0	112,244	47,544	159,788	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,940	2,516	8,456	264	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,000	13,978	46,978	211	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	390,985	165,614	556,599	3,433	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	15,972	6,765	22,737	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	287,386	121,731	409,117	630	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,510	29,867	100,377	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	145,464	61,616	207,080	1,086	54.00
60.00	06000	LABORATORY	0	60,104	25,459	85,563	994	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	2	62.00
65.00	06500	RESPIRATORY THERAPY	0	90,376	38,282	128,658	622	65.00
66.00	06600	PHYSICAL THERAPY	0	44,440	18,824	63,264	597	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,294	8,173	27,467	186	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,142	4,296	14,438	87	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,154	14,043	47,197	104	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,657	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	713	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	235	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	98,890	41,888	140,778	392	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	34,804	14,742	49,546	376	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	95	90.03
91.00	09100	EMERGENCY	0	150,854	63,899	214,753	995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	99,000	41,935	140,935	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,640,598	1,118,506	3,759,104	17,135	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,558	12,944	43,502	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	967	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,671,156	1,131,450	3,802,606	18,102	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	294,159					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	29,955	273,352				5.02
7.00	00700	OPERATION OF PLANT	20,444	22,025	776,881			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	682	735	1,934	9,615		8.00
9.00	00900	HOUSEKEEPING	4,235	4,562	13,009	1,815	66,116	9.00
10.00	01000	DIETARY	3,098	3,338	49,346	0	4,282	10.00
11.00	01100	CAFETERIA	2,726	2,937	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,604	2,805	2,611	0	227	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,824	3,042	14,508	0	1,259	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,213	53,020	171,891	2,905	14,914	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	197	212	7,022	0	609	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,355	10,079	126,345	677	10,963	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	868	935	30,999	0	2,690	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,744	13,730	63,951	931	5,549	54.00
60.00	06000	LABORATORY	19,146	20,626	26,424	78	2,293	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	631	680	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	6,969	7,508	39,732	82	3,448	65.00
66.00	06600	PHYSICAL THERAPY	6,063	6,531	19,537	203	1,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,845	1,987	8,482	0	736	67.00
68.00	06800	SPEECH PATHOLOGY	925	996	4,459	0	387	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,915	6,373	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	893	962	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,816	21,348	14,576	0	1,265	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,914	30,072	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,233	8,870	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	2,411	2,597	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	5,027	5,416	43,475	330	3,773	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	3,475	3,744	15,301	0	1,328	90.02
90.03	09003	ORTHOPEDIC CLINIC	819	883	0	0	0	90.03
91.00	09100	EMERGENCY	23,509	25,326	66,321	2,567	5,755	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,775	11,608	43,524	27	3,777	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	283,311	272,947	763,447	9,615	64,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	376	405	13,434	0	1,166	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,472	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	294,159	273,352	776,881	9,615	66,116	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
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	219,852					10.00
11.00	01100	CAFETERIA	0	5,663				11.00
13.00	01300	NURSING ADMINISTRATION	0	150	17,117			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	184	0	69,006		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	219,852	1,600	9,689	19,746	1,102,862	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	30,777	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	313	1,896	888	570,263	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	135,869	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	624	0	2,884	308,579	54.00
60.00	06000	LABORATORY	0	750	0	4,438	160,312	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1,313	62.00
65.00	06500	RESPIRATORY THERAPY	0	394	0	3,550	190,963	65.00
66.00	06600	PHYSICAL THERAPY	0	302	0	888	99,080	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	102	0	0	40,805	67.00
68.00	06800	SPEECH PATHOLOGY	0	37	0	888	22,217	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	12,288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	109	0	0	104,415	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	60,643	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	17,816	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	5,243	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	305	1,850	19,748	221,094	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	185	0	0	73,955	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	1,797	90.03
91.00	09100	EMERGENCY	0	608	3,682	13,535	357,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	2,441	213,087	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219,852	5,663	17,117	69,006	3,732,284	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	58,883	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	11,439	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	219,852	5,663	17,117	69,006	3,802,606	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	ADMINISTRATIVE AND GENERAL				5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER				5.02
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,102,862		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	30,777		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	570,263		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	135,869		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	308,579		54.00
60.00	06000	LABORATORY	0	160,312		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,313		62.00
65.00	06500	RESPIRATORY THERAPY	0	190,963		65.00
66.00	06600	PHYSICAL THERAPY	0	99,080		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40,805		67.00
68.00	06800	SPEECH PATHOLOGY	0	22,217		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,288		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,855		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	104,415		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	60,643		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	17,816		88.01
88.02	08803	RURAL HEALTH CLINIC III	0	5,243		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	0	221,094		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
90.02	09002	WOUND CARE	0	73,955		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	1,797		90.03
91.00	09100	EMERGENCY	0	357,051		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	213,087		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,732,284		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,883		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,439		192.00
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	3,802,606		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	121,416					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		121,416				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	578	578	13,566,421			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	9,350	9,350	995,766	-2,748,493	34,006,157	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	7,726	7,726	1,070,658	0	3,463,031	5.02
7.00	00700	OPERATION OF PLANT	23,439	23,439	246,401	0	2,363,495	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200	200	0	0	78,875	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	277,989	0	489,587	9.00
10.00	01000	DIETARY	5,102	5,102	0	0	358,161	10.00
11.00	01100	CAFETERIA	0	0	0	0	315,152	11.00
13.00	01300	NURSING ADMINISTRATION	270	270	198,191	0	300,986	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,500	158,036	0	326,471	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,772	17,772	2,571,084	0	5,688,761	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	726	726	0	0	22,737	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,063	13,063	472,033	0	1,081,547	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,205	3,205	0	0	100,377	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,612	6,612	813,902	0	1,473,305	54.00
60.00	06000	LABORATORY	2,732	2,732	744,960	0	2,213,398	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1,343	0	72,934	62.00
65.00	06500	RESPIRATORY THERAPY	4,108	4,108	466,025	0	805,683	65.00
66.00	06600	PHYSICAL THERAPY	2,020	2,020	447,628	0	700,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	877	877	139,246	0	213,264	67.00
68.00	06800	SPEECH PATHOLOGY	461	461	65,446	0	106,908	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	683,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	103,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,507	1,507	77,808	0	2,290,836	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,991,942	0	3,227,015	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	534,357	0	951,788	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	176,361	0	278,671	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	4,495	4,495	293,901	0	581,170	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	1,582	1,582	281,498	0	401,741	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	70,884	0	94,731	90.03
91.00	09100	EMERGENCY	6,857	6,857	745,790	0	2,717,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,500	4,500	0	0	1,245,661	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,027	120,027	12,841,249	-2,748,493	32,752,016	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,389	1,389	0	0	43,502	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	725,172	0	1,210,639	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,671,156	1,131,450	3,230,958		2,748,493	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.000033	9.318788	0.238158		0.080823	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,102		294,159	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001334		0.008650	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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL - OTHER (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	-3,742,924	31,703,240				5.02
7.00	00700	OPERATION OF PLANT	0	2,554,520	80,323			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,250	200	8,419		8.00
9.00	00900	HOUSEKEEPING	0	529,157	1,345	1,589	78,778	9.00
10.00	01000	DIETARY	0	387,109	5,102	0	5,102	10.00
11.00	01100	CAFETERIA	0	340,624	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	325,313	270	0	270	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	352,857	1,500	0	1,500	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,148,556	17,772	2,543	17,772	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	24,575	726	0	726	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,168,961	13,063	593	13,063	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	108,490	3,205	0	3,205	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,592,382	6,612	815	6,612	54.00
60.00	06000	LABORATORY	0	2,392,291	2,732	68	2,732	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	78,829	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	870,801	4,108	72	4,108	65.00
66.00	06600	PHYSICAL THERAPY	0	757,527	2,020	178	2,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	230,501	877	0	877	67.00
68.00	06800	SPEECH PATHOLOGY	0	115,549	461	0	461	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	739,141	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	111,569	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,475,988	1,507	0	1,507	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,487,832	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,028,714	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	301,194	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	628,142	4,495	289	4,495	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	434,211	1,582	0	1,582	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	102,387	0	0	0	90.03
91.00	09100	EMERGENCY	0	2,937,413	6,857	2,248	6,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,346,339	4,500	24	4,500	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,742,924	31,656,222	78,934	8,419	77,389	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,018	1,389	0	1,389	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-1,308,486	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,742,924	2,856,109	102,427	658,787	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.118061	35.557798	12.166172	8.362576	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		273,352	776,881	9,615	66,116	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.008622	9.671962	1.142060	0.839270	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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 6/11/2021 11:56 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			10.00	11.00	13.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
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	8,690					10.00
11.00	01100	CAFETERIA	0	11,854				11.00
13.00	01300	NURSING ADMINISTRATION	0	315	122,992			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	386	0	311		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,690	3,347	69,618	89		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	655	13,620	4		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,306	0	13		54.00
60.00	06000	LABORATORY	0	1,570	0	20		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	824	0	16		65.00
66.00	06600	PHYSICAL THERAPY	0	633	0	4		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	213	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	77	0	4		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	229	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0		88.03
90.00	09000	CLINIC	0	639	13,294	89		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0		90.01
90.02	09002	WOUND CARE	0	388	0	0		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	0	1,272	26,460	61		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	11		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,690	11,854	122,992	311		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
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)	656,893	380,838	385,699	472,798		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	75.591830	32.127383	3.135968	1,520.250804		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	219,852	5,663	17,117	69,006		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	25.299425	0.477729	0.139172	221.884244		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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,804,006		8,804,006	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	59,362		59,362	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,957,753		1,957,753	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,063		262,063	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,142,417		2,142,417	0	0	54.00
60.00	06000	LABORATORY	2,876,390		2,876,390	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88,136		88,136	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,205,706	0	1,205,706	0	0	65.00
66.00	06600	PHYSICAL THERAPY	964,264	0	964,264	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	303,075	0	303,075	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	157,993	0	157,993	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	826,405		826,405	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,741		124,741	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,841,851		2,841,851	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,899,609		3,899,609	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,150,165		1,150,165	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	336,753		336,753	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
90.00	09000	CLINIC	1,100,760		1,100,760	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	567,421		567,421	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	114,475		114,475	0	0	90.03
91.00	09100	EMERGENCY	3,829,298		3,829,298	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,156,139		1,156,139		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,719,946		1,719,946	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	36,488,728	0	36,488,728	0	0	200.00
201.00		Less Observation Beds	1,156,139		1,156,139		0	201.00
202.00		Total (see instructions)	35,332,589	0	35,332,589	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 11:56 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	5,645,721		5,645,721			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	114,390		114,390			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,129,303	5,284,842	6,414,145	0.305224	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	441,551	176,304	617,855	0.424150	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,349,753	16,029,565	17,379,318	0.123274	0.000000	54.00
60.00	06000	LABORATORY	1,651,392	16,161,674	17,813,066	0.161476	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	60,258	219,522	279,780	0.315019	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,007,330	2,138,608	3,145,938	0.383258	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	589,420	2,042,646	2,632,066	0.366353	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	484,480	544,123	1,028,603	0.294647	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	114,663	285,554	400,217	0.394768	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,527,194	2,488,711	4,015,905	0.205783	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	129,032	129,032	0.966745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,519,659	9,692,346	13,212,005	0.215096	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,134,701	4,134,701			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,593,187	1,593,187			88.01
88.02	08803	RURAL HEALTH CLINIC III	0	484,904	484,904			88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0			88.03
90.00	09000	CLINIC	80,350	831,130	911,480	1.207662	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	20,552	1,777,143	1,797,695	0.315638	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	585,127	585,127	0.195641	0.000000	90.03
91.00	09100	EMERGENCY	422,027	7,353,453	7,775,480	0.492484	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,017	685,623	727,640	1.588889	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,960,372	3,960,372	0.434289	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	18,200,060	76,598,567	94,798,627			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,200,060	76,598,567	94,798,627			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08803	RURAL HEALTH CLINIC III		88.02
88.03	08802	RURAL HEALTH CLINIC IV		88.03
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	90.01
90.02	09002	WOUND CARE	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,804,006		8,804,006	0	8,804,006	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	59,362		59,362	0	59,362	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,957,753		1,957,753	0	1,957,753	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,063		262,063	0	262,063	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,142,417		2,142,417	0	2,142,417	54.00
60.00	06000	LABORATORY	2,876,390		2,876,390	0	2,876,390	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88,136		88,136	0	88,136	62.00
65.00	06500	RESPIRATORY THERAPY	1,205,706	0	1,205,706	0	1,205,706	65.00
66.00	06600	PHYSICAL THERAPY	964,264	0	964,264	0	964,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	303,075	0	303,075	0	303,075	67.00
68.00	06800	SPEECH PATHOLOGY	157,993	0	157,993	0	157,993	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	826,405		826,405	0	826,405	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,741		124,741	0	124,741	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,841,851		2,841,851	0	2,841,851	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,899,609		3,899,609	0	3,899,609	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,150,165		1,150,165	0	1,150,165	88.01
88.02	08803	RURAL HEALTH CLINIC III	336,753		336,753	0	336,753	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
90.00	09000	CLINIC	1,100,760		1,100,760	0	1,100,760	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	567,421		567,421	0	567,421	90.02
90.03	09003	ORTHOPEDIC CLINIC	114,475		114,475	0	114,475	90.03
91.00	09100	EMERGENCY	3,829,298		3,829,298	0	3,829,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,156,139		1,156,139		1,156,139	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,719,946		1,719,946	0	1,719,946	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	36,488,728	0	36,488,728	0	36,488,728	200.00
201.00		Less Observation Beds	1,156,139		1,156,139		1,156,139	201.00
202.00		Total (see instructions)	35,332,589	0	35,332,589	0	35,332,589	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,645,721		5,645,721			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	114,390		114,390			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,129,303	5,284,842	6,414,145	0.305224	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	441,551	176,304	617,855	0.424150	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,349,753	16,029,565	17,379,318	0.123274	0.000000	54.00
60.00	06000	LABORATORY	1,651,392	16,161,674	17,813,066	0.161476	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	60,258	219,522	279,780	0.315019	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,007,330	2,138,608	3,145,938	0.383258	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	589,420	2,042,646	2,632,066	0.366353	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	484,480	544,123	1,028,603	0.294647	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	114,663	285,554	400,217	0.394768	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,527,194	2,488,711	4,015,905	0.205783	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	129,032	129,032	0.966745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,519,659	9,692,346	13,212,005	0.215096	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,134,701	4,134,701	0.943142	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,593,187	1,593,187	0.721927	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	484,904	484,904	0.694474	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0.000000	0.000000	88.03
90.00	09000	CLINIC	80,350	831,130	911,480	1.207662	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	20,552	1,777,143	1,797,695	0.315638	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	585,127	585,127	0.195641	0.000000	90.03
91.00	09100	EMERGENCY	422,027	7,353,453	7,775,480	0.492484	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	42,017	685,623	727,640	1.588889	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,960,372	3,960,372	0.434289	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	18,200,060	76,598,567	94,798,627			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,200,060	76,598,567	94,798,627			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.305224		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.424150		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123274		54.00
60.00	06000	LABORATORY	0.161476		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315019		62.00
65.00	06500	RESPIRATORY THERAPY	0.383258		65.00
66.00	06600	PHYSICAL THERAPY	0.366353		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294647		67.00
68.00	06800	SPEECH PATHOLOGY	0.394768		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205783		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.966745		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215096		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.943142		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.721927		88.01
88.02	08803	RURAL HEALTH CLINIC III	0.694474		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000		88.03
90.00	09000	CLINIC	1.207662		90.00
90.01	09001	PAIN MANAGEMENT	0.000000		90.01
90.02	09002	WOUND CARE	0.315638		90.02
90.03	09003	ORTHOPEDIC CLINIC	0.195641		90.03
91.00	09100	EMERGENCY	0.492484		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.588889		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.434289		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,957,753	570,263	1,387,490	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,063	135,869	126,194	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,142,417	308,579	1,833,838	0	0	54.00
60.00	06000	LABORATORY	2,876,390	160,312	2,716,078	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88,136	1,313	86,823	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,205,706	190,963	1,014,743	0	0	65.00
66.00	06600	PHYSICAL THERAPY	964,264	99,080	865,184	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	303,075	40,805	262,270	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	157,993	22,217	135,776	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	826,405	12,288	814,117	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,741	1,855	122,886	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,841,851	104,415	2,737,436	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,899,609	60,643	3,838,966	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,150,165	17,816	1,132,349	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	336,753	5,243	331,510	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	1,100,760	221,094	879,666	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	567,421	73,955	493,466	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	114,475	1,797	112,678	0	0	90.03
91.00	09100	EMERGENCY	3,829,298	357,051	3,472,247	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,156,139	144,827	1,011,312	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,719,946	213,087	1,506,859	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	27,625,360	2,743,472	24,881,888	0	0	200.00
201.00		Less Observation Beds	1,156,139	144,827	1,011,312	0	0	201.00
202.00		Total (line 200 minus line 201)	26,469,221	2,598,645	23,870,576	0	0	202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,957,753	6,414,145	0.305224		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	262,063	617,855	0.424150		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,142,417	17,379,318	0.123274		54.00
60.00	06000	LABORATORY	2,876,390	17,813,066	0.161476		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88,136	279,780	0.315019		62.00
65.00	06500	RESPIRATORY THERAPY	1,205,706	3,145,938	0.383258		65.00
66.00	06600	PHYSICAL THERAPY	964,264	2,632,066	0.366353		66.00
67.00	06700	OCCUPATIONAL THERAPY	303,075	1,028,603	0.294647		67.00
68.00	06800	SPEECH PATHOLOGY	157,993	400,217	0.394768		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	826,405	4,015,905	0.205783		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,741	129,032	0.966745		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,841,851	13,212,005	0.215096		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,899,609	4,134,701	0.943142		88.00
88.01	08801	RURAL HEALTH CLINIC II	1,150,165	1,593,187	0.721927		88.01
88.02	08803	RURAL HEALTH CLINIC III	336,753	484,904	0.694474		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0.000000		88.03
90.00	09000	CLINIC	1,100,760	911,480	1.207662		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000		90.01
90.02	09002	WOUND CARE	567,421	1,797,695	0.315638		90.02
90.03	09003	ORTHOPEDIC CLINIC	114,475	585,127	0.195641		90.03
91.00	09100	EMERGENCY	3,829,298	7,775,480	0.492484		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,156,139	727,640	1.588889		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,719,946	3,960,372	0.434289		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	27,625,360	89,038,516			200.00
201.00		Less Observation Beds	1,156,139	0			201.00
202.00		Total (line 200 minus line 201)	26,469,221	89,038,516			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 6/11/2021 11:56 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	570,263	6,414,145	0.088907	108,655	9,660	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,869	617,855	0.219904	6,192	1,362	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,579	17,379,318	0.017756	564,192	10,018	54.00
60.00	06000	LABORATORY	160,312	17,813,066	0.009000	597,418	5,377	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,313	279,780	0.004693	15,115	71	62.00
65.00	06500	RESPIRATORY THERAPY	190,963	3,145,938	0.060701	436,816	26,515	65.00
66.00	06600	PHYSICAL THERAPY	99,080	2,632,066	0.037643	157,700	5,936	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,805	1,028,603	0.039670	102,509	4,067	67.00
68.00	06800	SPEECH PATHOLOGY	22,217	400,217	0.055512	35,703	1,982	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,288	4,015,905	0.003060	568,377	1,739	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,855	129,032	0.014376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,415	13,212,005	0.007903	1,638,382	12,948	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	60,643	4,134,701	0.014667	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	17,816	1,593,187	0.011183	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	5,243	484,904	0.010812	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
90.00	09000	CLINIC	221,094	911,480	0.242566	34,499	8,368	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	73,955	1,797,695	0.041139	9,823	404	90.02
90.03	09003	ORTHOPEDIC CLINIC	1,797	585,127	0.003071	0	0	90.03
91.00	09100	EMERGENCY	357,051	7,775,480	0.045920	18,878	867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	144,827	727,640	0.199037	3,856	767	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,530,385	85,078,144		4,298,115	90,081	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 11:56 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	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	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,414,145	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	617,855	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,379,318	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,813,066	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	279,780	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,145,938	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,632,066	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,028,603	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	400,217	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,015,905	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	129,032	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,212,005	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,134,701	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,593,187	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	484,904	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
90.00	09000	CLINIC	0	0	0	911,480	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	1,797,695	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	585,127	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	7,775,480	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	727,640	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	85,078,144		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 11:56 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	108,655	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	6,192	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	564,192	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	597,418	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	15,115	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	436,816	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	157,700	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	102,509	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	35,703	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	568,377	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,638,382	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	34,499	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	9,823	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	18,878	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,856	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,298,115	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/11/2021 11:56 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	0.305224	0	1,175,343	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.424150	0	484	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123274	0	5,143,870	0	0	54.00
60.00	06000	LABORATORY	0.161476	0	3,085,227	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315019	0	85,628	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.383258	0	646,269	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.366353	0	634,691	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294647	0	149,542	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.394768	0	33,828	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205783	0	650,702	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.966745	0	55,672	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215096	0	5,011,479	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08803	RURAL HEALTH CLINIC III						88.02
88.03	08802	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	1.207662	0	314,040	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.315638	0	966,628	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.195641	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.492484	0	2,135,353	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.588889	0	280,277	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.434289		0			95.00
200.00		Subtotal (see instructions)		0	20,369,033	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	20,369,033	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/11/2021 11:56 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	358,743	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	634,105	0	54.00
60.00	06000	LABORATORY	498,190	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	26,974	0	62.00
65.00	06500	RESPIRATORY THERAPY	247,688	0	65.00
66.00	06600	PHYSICAL THERAPY	232,521	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,062	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,354	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,903	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,821	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077,949	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08803	RURAL HEALTH CLINIC III			88.02
88.03	08802	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	379,254	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	305,105	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	90.03
91.00	09100	EMERGENCY	1,051,627	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	445,329	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,502,830	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,502,830	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I | Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,102,862	297,724	805,138	2,485	324.00	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	30,777		30,777	121	254.36	43.00
200.00	Total (lines 30 through 199)	1,133,639		835,915	2,606		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	41	13,284		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	6	1,526		43.00
200.00	Total (lines 30 through 199)	47	14,810		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	570,263	6,414,145	0.088907	374,939	33,335	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,869	617,855	0.219904	164,284	36,127	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,579	17,379,318	0.017756	110,799	1,967	54.00
60.00	06000	LABORATORY	160,312	17,813,066	0.009000	151,650	1,365	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,313	279,780	0.004693	5,811	27	62.00
65.00	06500	RESPIRATORY THERAPY	190,963	3,145,938	0.060701	40,401	2,452	65.00
66.00	06600	PHYSICAL THERAPY	99,080	2,632,066	0.037643	4,848	182	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,805	1,028,603	0.039670	1,519	60	67.00
68.00	06800	SPEECH PATHOLOGY	22,217	400,217	0.055512	453	25	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,288	4,015,905	0.003060	159,028	487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,855	129,032	0.014376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,415	13,212,005	0.007903	248,359	1,963	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	60,643	4,134,701	0.014667	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	17,816	1,593,187	0.011183	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	5,243	484,904	0.010812	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
90.00	09000	CLINIC	221,094	911,480	0.242566	24,111	5,849	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	73,955	1,797,695	0.041139	9,692	399	90.02
90.03	09003	ORTHOPEDIC CLINIC	1,797	585,127	0.003071	0	0	90.03
91.00	09100	EMERGENCY	357,051	7,775,480	0.045920	73,328	3,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	144,827	727,640	0.199037	11,065	2,202	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,530,385	85,078,144		1,380,287	89,807	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,485	0.00	41	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	121	0.00	6	43.00
200.00		Total (lines 30 through 199)		0	2,606		47	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	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	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,414,145	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	617,855	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,379,318	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,813,066	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	279,780	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,145,938	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,632,066	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,028,603	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	400,217	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,015,905	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	129,032	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,212,005	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,134,701	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,593,187	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	484,904	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
90.00	09000	CLINIC	0	0	0	911,480	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	1,797,695	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	585,127	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	7,775,480	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	727,640	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	85,078,144		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	374,939	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	164,284	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	110,799	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	151,650	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	5,811	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	40,401	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,848	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,519	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	453	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	159,028	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	248,359	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	24,111	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	9,692	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	73,328	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	11,065	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,380,287	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.305224	0	798,477	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.424150	0	27,434	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123274	0	1,876,401	0	0	54.00
60.00	06000	LABORATORY	0.161476	0	1,839,691	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315019	0	13,884	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.383258	0	172,039	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.366353	0	219,667	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294647	0	57,160	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.394768	0	34,363	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205783	0	436,030	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.966745	0	4,865	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215096	0	650,250	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08803	RURAL HEALTH CLINIC III						88.02
88.03	08802	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	1.207662	0	89,067	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.315638	0	102,183	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.195641	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.492484	0	1,100,739	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.588889	0	57,775	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.434289	0	0			95.00
200.00		Subtotal (see instructions)		0	7,480,025	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	7,480,025	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	243,714	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,636	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	231,311	0	54.00
60.00	06000	LABORATORY	297,066	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,374	0	62.00
65.00	06500	RESPIRATORY THERAPY	65,935	0	65.00
66.00	06600	PHYSICAL THERAPY	80,476	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,842	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,565	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,728	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,703	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	139,866	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08803	RURAL HEALTH CLINIC III			88.02
88.03	08802	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	107,563	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	32,253	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	90.03
91.00	09100	EMERGENCY	542,096	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	91,798	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	1,972,926	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	1,972,926	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 11:56 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)	3,622	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,485	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,038	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	905	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	232	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,147	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)	905	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	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,804,006	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)	35,965	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)	2,376,693	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,427,313	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,427,313	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,586.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,966,647	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,966,647	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 11:56 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,005,615	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,972,262	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)	2,340,728	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)	2,340,728	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)	447	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,586.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,156,139	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 11:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,102,862	8,804,006	0.125268	1,156,139	144,827	90.00
91.00	Nursing School cost	0	8,804,006	0.000000	1,156,139	0	91.00
92.00	Allied health cost	0	8,804,006	0.000000	1,156,139	0	92.00
93.00	All other Medical Education	0	8,804,006	0.000000	1,156,139	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 6/11/2021 11:56 am
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,622	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,485	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,038	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	905	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	232	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)	41	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)	905	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	232	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)	121	15.00
16.00	Nursery days (title V or XIX only)	6	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	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,804,006	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)	35,965	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)	2,376,693	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,427,313	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,427,313	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,586.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	106,044	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)	106,044	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	59,362	121	490.60	6	2,944	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	414,003	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	522,991	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)	14,810	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	89,807	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	104,617	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	418,374	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)	2,340,728	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)	2,340,728	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)	35,965	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)	35,965	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)	447	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,586.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,156,139	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,102,862	8,804,006	0.125268	1,156,139	144,827	90.00
91.00	Nursing School cost	0	8,804,006	0.000000	1,156,139	0	91.00
92.00	Allied health cost	0	8,804,006	0.000000	1,156,139	0	92.00
93.00	All other Medical Education	0	8,804,006	0.000000	1,156,139	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/11/2021 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,874,074		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.305224	108,655	33,164	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.424150	6,192	2,626	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123274	564,192	69,550	54.00
60.00	06000	LABORATORY	0.161476	597,418	96,469	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315019	15,115	4,762	62.00
65.00	06500	RESPIRATORY THERAPY	0.383258	436,816	167,413	65.00
66.00	06600	PHYSICAL THERAPY	0.366353	157,700	57,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294647	102,509	30,204	67.00
68.00	06800	SPEECH PATHOLOGY	0.394768	35,703	14,094	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205783	568,377	116,962	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.966745	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215096	1,638,382	352,409	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	1.207662	34,499	41,663	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.315638	9,823	3,101	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.195641	0	0	90.03
91.00	09100	EMERGENCY	0.492484	18,878	9,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.588889	3,856	6,127	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,298,115	1,005,615	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,298,115		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/11/2021 11:56 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.305224	1,598	488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.424150	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123274	13,227	1,631	54.00
60.00	06000	LABORATORY	0.161476	113,389	18,310	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315019	2,512	791	62.00
65.00	06500	RESPIRATORY THERAPY	0.383258	162,246	62,182	65.00
66.00	06600	PHYSICAL THERAPY	0.366353	306,314	112,219	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294647	279,589	82,380	67.00
68.00	06800	SPEECH PATHOLOGY	0.394768	59,506	23,491	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205783	173,021	35,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.966745	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215096	359,518	77,331	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	1.207662	1,174	1,418	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.315638	163	51	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.195641	0	0	90.03
91.00	09100	EMERGENCY	0.492484	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.588889	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,472,257	415,897	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,472,257		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 6/11/2021 11:56 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		247,021		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		5,580		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.305224	374,939	114,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.424150	164,284	69,681	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.123274	110,799	13,659	54.00
60.00	06000	LABORATORY	0.161476	151,650	24,488	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315019	5,811	1,831	62.00
65.00	06500	RESPIRATORY THERAPY	0.383258	40,401	15,484	65.00
66.00	06600	PHYSICAL THERAPY	0.366353	4,848	1,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294647	1,519	448	67.00
68.00	06800	SPEECH PATHOLOGY	0.394768	453	179	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.205783	159,028	32,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.966745	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215096	248,359	53,421	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.943142	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.721927	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0.694474	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
90.00	09000	CLINIC	1.207662	24,111	29,118	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.315638	9,692	3,059	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.195641	0	0	90.03
91.00	09100	EMERGENCY	0.492484	73,328	36,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.588889	11,065	17,581	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,380,287	414,003	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)		1,380,287		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 6/11/2021 11:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,502,830	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)	5,502,830	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)	5,557,858	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)	56,285	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,485,874	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)	2,015,699	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)	2,015,699	30.00
31.00	Primary payer payments	137	31.00
32.00	Subtotal (line 30 minus line 31)	2,015,562	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)	429,385	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	279,100	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	290,648	36.00
37.00	Subtotal (see instructions)	2,294,662	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)	2,294,662	40.00
40.01	Sequestration adjustment (see instructions)	15,145	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	2,220,897	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)	58,620	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: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 6/11/2021 11:56 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,341,834		2,220,897	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/13/2020	268,600		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)		268,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,610,434		2,220,897	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		90,953		58,620	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,701,387		2,279,517	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: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 6/11/2021 11:56 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		2,209,064		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	07/13/2020	362,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		362,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,571,064		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		191,080		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,762,144		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: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 6/11/2021 11:56 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: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 6/11/2021 11:56 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)	2,364,135	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)	420,056	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	905	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)	2,784,191	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,784,191	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)	2,784,191	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,696	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,780,495	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)	2,780,495	0	19.00
19.01	Sequestration adjustment (see instructions)	18,351	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	2,571,064	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)	191,080	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: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 6/11/2021 11:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,972,262	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,972,262	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,011,985	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,011,985	19.00
20.00	Deductibles (exclude professional component)	316,712	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,695,273	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,695,273	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,239	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	30,705	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,532	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,725,978	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,725,978	30.00
30.01	Sequestration adjustment (see instructions)	24,591	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,610,434	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)	90,953	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 6/11/2021 11:56 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	12,734,144	0	0	0	1.00
2.00	Temporary investments	3,179,496	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,557,683	0	0	0	4.00
5.00	Other receivable	-458,300	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,430,354	0	0	0	6.00
7.00	Inventory	726,796	0	0	0	7.00
8.00	Prepaid expenses	376,977	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,820,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,506,442	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,815,753	0	0	0	12.00
13.00	Land improvements	59,357	0	0	0	13.00
14.00	Accumulated depreciation	-11,237,575	0	0	0	14.00
15.00	Buildings	44,070,776	0	0	0	15.00
16.00	Accumulated depreciation	-2,739,236	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	2,418,589	0	0	0	19.00
20.00	Accumulated depreciation	-170,349	0	0	0	20.00
21.00	Automobiles and trucks	477,834	0	0	0	21.00
22.00	Accumulated depreciation	-379,809	0	0	0	22.00
23.00	Major movable equipment	17,244,501	0	0	0	23.00
24.00	Accumulated depreciation	-9,482,113	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)	44,077,728	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	67,584,170	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,556,849	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	518,654	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,031,010	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,283,549	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,390,062	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	36,052,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	36,052,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	41,442,062	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	26,142,108				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)	26,142,108	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	67,584,170	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 6/11/2021 11:56 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		23,064,288		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,489,423				2.00
3.00	Total (sum of line 1 and line 2)		25,553,711		0		3.00
4.00	FREE STANDING HOME HEALTH	588,397		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		588,397		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,142,108		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,142,108		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	FREE STANDING HOME HEALTH		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/11/2021 11:56 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,620,337		5,620,337	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)	5,620,337		5,620,337	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	150,506		150,506	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)	150,506		150,506	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,770,843		5,770,843	17.00
18.00	Ancillary services	12,406,954	67,672,041	80,078,995	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	4,134,701	4,134,701	20.00
20.01	RURAL HEALTH CLINIC II	0	1,593,187	1,593,187	20.01
20.02	RURAL HEALTH CLINIC III	0	484,904	484,904	20.02
20.03	RURAL HEALTH CLINIC IV	0	0	0	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	3,960,372	3,960,372	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,177,797	77,845,205	96,023,002	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,751,772		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)		39,751,772		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1322	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 6/11/2021 11:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	96,023,002	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,059,337	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,963,665	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,751,772	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,788,107	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	380,725	6.00
7.00	Income from investments	78,632	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	45,497	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	71,532	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	60,038	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	3,362,745	24.00
24.50	COVID-19 PHE Funding	3,278,361	24.50
25.00	Total other income (sum of lines 6-24)	7,277,530	25.00
26.00	Total (line 5 plus line 25)	2,489,423	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,489,423	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/11/2021 11:56 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	1,279,460	0	1,279,460	-18,343	1,261,117	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	187,981	0	187,981	-17,250	170,731	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	191,367	0	191,367	0	191,367	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	184,328	0	184,328	0	184,328	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,843,136	0	1,843,136	-35,593	1,807,543	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	14,043	14,043	0	14,043	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,043	14,043	0	14,043	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,843,136	14,043	1,857,179	-35,593	1,821,586	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	37,562	37,562	0	37,562	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	37,562	37,562	0	37,562	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	200,295	690,552	890,847	2,861	893,708	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	200,295	690,552	890,847	2,861	893,708	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,043,431	742,157	2,785,588	-32,732	2,752,856	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/11/2021 11:56 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,261,117		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	170,731		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	191,367		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	184,328		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,807,543		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	14,043		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,043		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,821,586		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	37,562		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	37,562		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-238	893,470		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-238	893,470		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-238	2,752,618		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/11/2021 11:56 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	327,764	0	327,764	0	327,764	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	38,521	0	38,521	2,088	40,609	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	25,338	0	25,338	0	25,338	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	96,021	0	96,021	0	96,021	9.00
10.00	Subtotal (sum of lines 1 through 9)	487,644	0	487,644	2,088	489,732	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	801	801	0	801	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	801	801	0	801	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	487,644	801	488,445	2,088	490,533	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	121,293	121,293	0	121,293	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	121,293	121,293	0	121,293	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	44,625	170,202	214,827	-2,066	212,761	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	44,625	170,202	214,827	-2,066	212,761	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	532,269	292,296	824,565	22	824,587	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/11/2021 11:56 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	327,764		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	40,609		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	25,338		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	96,021		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	489,732		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	801		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	801		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	490,533		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	121,293		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	121,293		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-60	212,701		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-60	212,701		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-60	824,527		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/11/2021 11:56 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	13,943	13,943	0	13,943	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	83,129	0	83,129	24,646	107,775	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	6,075	0	6,075	0	6,075	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	89,204	13,943	103,147	24,646	127,793	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	216	216	0	216	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	216	216	0	216	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	89,204	14,159	103,363	24,646	128,009	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	6,298	6,298	0	6,298	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	6,298	6,298	0	6,298	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	62,511	41,917	104,428	-2,066	102,362	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	62,511	41,917	104,428	-2,066	102,362	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	151,715	62,374	214,089	22,580	236,669	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1

Component CCN: 15-8518 | Date/Time Prepared: 6/11/2021 11:56 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	13,943		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	107,775		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	6,075		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	127,793		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	216		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	216		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	128,009		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	6,298		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	6,298		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	102,362		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	102,362		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	236,669		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8519 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 6/11/2021 11:56 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	0	0	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	0	0	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	3,773	3,773	0	3,773	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	3,773	3,773	0	3,773	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,773	3,773	0	3,773	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1

Component CCN: 15-8519 | Date/Time Prepared: 6/11/2021 11:56 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	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0		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	-3,773	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,773	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,773	0		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 6/11/2021 11:56 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	2.50	9,801	4,200	10,500		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.37	7,079	2,100	4,977		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.87	16,880		15,477	16,880	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.87	16,880			16,880	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,821,586	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					37,562	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,859,148	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.979796	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					893,470	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,146,991	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,040,461	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,040,461	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,999,236	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,820,822	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 6/11/2021 11:56 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.72	3,168	4,200	3,024		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.59	2,413	2,100	1,239		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.31	5,581		4,263	5,581	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)	1.31	5,581			5,581	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)					490,533	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					121,293	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					611,826	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.801752	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					212,701	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					325,638	15.00
16.00	Total overhead (sum of lines 14 and 15)					538,339	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					538,339	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					431,614	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					922,147	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 6/11/2021 11:56 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.04	141	4,200	168		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.79	1,706	2,100	1,659		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.83	1,847		1,827	1,847	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)	0.83	1,847			1,847	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)					128,009	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					6,298	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					134,307	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.953107	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					102,362	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					100,084	15.00
16.00	Total overhead (sum of lines 14 and 15)					202,446	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					202,446	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					192,953	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					320,962	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 6/11/2021 11:56 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)		3,820,822	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		142,711	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,678,111	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		16,880	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)		16,880	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		217.90	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)	217.90	217.90	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,264	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	493,326	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	493,326	16.00
16.01	Total program charges (see instructions)(from contractor's records)		626,798	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		68,192	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		53,671	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.)		309,361	16.04
16.05	Total program cost (see instructions)	0	363,032	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		52,954	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		95,800	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		363,032	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		35,411	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		398,443	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)		398,443	26.00
26.01	Sequestration adjustment (see instructions)		2,630	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		445,072	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)		-49,259	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: 15-1322 Component CCN: 15-8517	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 6/11/2021 11:56 am
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		922,147	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		44,707	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		877,440	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,581	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)		5,581	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		157.22	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)	157.22	157.22	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	115	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	18,080	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	18,080	16.00
16.01	Total program charges (see instructions)(from contractor's records)		23,922	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,388	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,316	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.)		7,974	16.04
16.05	Total program cost (see instructions)	0	11,290	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,797	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,947	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		11,290	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,845	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		16,135	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)		16,135	26.00
26.01	Sequestration adjustment (see instructions)		106	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		15,426	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)		603	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: 15-1322 Component CCN: 15-8518	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 6/11/2021 11:56 am
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		320,962	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		23,717	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		297,245	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,847	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)		1,847	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		160.93	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)	160.93	160.93	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	281	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	45,221	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	45,221	16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,800	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,436	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,547	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.)		26,801	16.04
16.05	Total program cost (see instructions)	0	30,348	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,173	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,438	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		30,348	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,961	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		35,309	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)		35,309	26.00
26.01	Sequestration adjustment (see instructions)		233	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		28,650	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)		6,426	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: 15-1322 Component CCN: 15-8516	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 6/11/2021 11:56 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,807,543	1,807,543	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002978	0.005890	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	5,383	10,646	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	37,688	14,320	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	43,071	24,966	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,821,586	1,821,586	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,999,236	1,999,236	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.023645	0.013706	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	47,272	27,402	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	90,343	52,368	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	181	358	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	499.13	146.28	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	56	51	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	27,951	7,460	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)		142,711	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)		35,411	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1322 Component CCN: 15-8517	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 6/11/2021 11:56 am
	Title XVIII	RHC II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	489,732	489,732	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003180	0.008930	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,557	4,373	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	12,012	5,840	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	13,569	10,213	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	490,533	490,533	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	431,614	431,614	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.027662	0.020820	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	11,939	8,986	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	25,508	19,199	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	52	146	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	490.54	131.50	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	8	7	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,924	921	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)		44,707	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)		4,845	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1322 Component CCN: 15-8518	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 6/11/2021 11:56 am
	Title XVIII	RHC III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	127,793	127,793	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002897	0.005118	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	370	654	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,315	2,120	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,685	2,774	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	128,009	128,009	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	192,953	192,953	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.052223	0.021670	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,077	4,181	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	16,762	6,955	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	30	53	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	558.73	131.23	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	8	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,911	1,050	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)		23,717	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)		4,961	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 6/11/2021 11:56 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		445,072	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)		445,072	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		49,259	6.02
7.00	Total Medicare program liability (see instructions)		395,813	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: 15-1322 Component CCN: 15-8517	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 6/11/2021 11:56 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		15,426	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)		15,426	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		603	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		16,029	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: 15-1322 Component CCN: 15-8518	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 6/11/2021 11:56 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		28,650	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)		28,650	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		6,426	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		35,076	7.00

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