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: 15-1305	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/19/2021 7:18 am

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically prepared cost report — Date: 4/19/2021 Time: 7:18 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 PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) GREGG MALOTT
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	654,507	676,334	0	17,272	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	388,236	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC- WINAMAC I	0		-23,628		0	10.00
10.01	RURAL HEALTH CLINIC NORTH JUDSON II	0		-63,578		0	10.01
10.02	RURAL HEALTH CLINIC FRANCESVILLE III	0		16,859		0	10.02
10.03	RURAL HEALTH CLINIC KNOX IV	0		6,862		0	10.03
200.00	Total	0	1,042,743	612,849	0	17,272	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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 4/19/2021 7:18 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 616 EAST 13TH	PO Box:			1.00
2.00	City: WINAMAC	State: IN	Zip Code: 46996-	County: PULASKI	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	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	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	PULASKI MEMORIAL HOSPITAL	157078	99915		10/14/1982	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	PULASKI MEMORIAL RHC - WINAMAC	158512	99915		08/21/2014	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PULASKI MEMORIAL RHC - NORTH JUDSON	158527	99915		03/14/2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	PULASKI MEMORIAL RHC - FRANCESVILLE	158528	99915		03/15/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	PULASKI MEMORIAL RHC - KNOX MEDICAL	158554	99915		07/06/2020	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2019	09/30/2020	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 4/19/2021 7:18 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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 4/19/2021 7:18 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/19/2021 7:18 am

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

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

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

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

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

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

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

Line	Description	V	XIX	
		1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

Line	Description	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

Line	Description		
		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

Line	Description			
		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

Line	Description				
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

Line	Description	Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	168,530	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 4/19/2021 7:18 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/19/2021 7:18 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part II | Date/Time Prepared: 4/19/2021 7:18 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	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/13/2021	Y	01/13/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1305	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/19/2021 7:18 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.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1305	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/19/2021 7:18 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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 4/19/2021 7:18 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	33,024.00	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	33,024.00	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	33,024.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC- WINAMAC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC NORTH JUDSON	88.01				0	26.01
26.02	RURAL HEALTH CLINIC FRANCESVILLE	88.02				0	26.02
26.03	RURAL HEALTH CLINIC KNOX	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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 4/19/2021 7:18 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)	761	26	1,376			1.00
2.00	HMO and other (see instructions)	58	111				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	429	0	429			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	149			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,190	26	1,954			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		0	146			13.00
14.00	Total (see instructions)	1,190	26	2,100	0.00	191.90	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	548	0	727	0.00	1.85	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- WINAMAC	5,297	301	21,570	0.00	39.00	26.00
26.01	RURAL HEALTH CLINIC NORTH JUDSON	1,791	7	4,759	0.00	6.30	26.01
26.02	RURAL HEALTH CLINIC FRANCESVILLE	360	29	1,377	0.00	3.26	26.02
26.03	RURAL HEALTH CLINIC KNOX	271	2	941	0.00	3.97	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	246.28	27.00
28.00	Observation Bed Days		54	320			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	6			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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 4/19/2021 7:18 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	179	12	381	1.00
2.00	HMO and other (see instructions)			16	54		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	179	12	381	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC- WINAMAC	0.00					26.00
26.01	RURAL HEALTH CLINIC NORTH JUDSON	0.00					26.01
26.02	RURAL HEALTH CLINIC FRANCESVILLE	0.00					26.02
26.03	RURAL HEALTH CLINIC KNOX	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

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-1305 | Component CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-4 | Date/Time Prepared: 4/19/2021 7:18 am

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	30.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.15	0.00	0.15	4.00
5.00	Other Administrative Personnel		0.29	0.00	0.29	5.00
6.00	Direct Nursing Service		0.56	0.00	0.56	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.11	0.00	0.11	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.03	0.00	0.03	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.01	0.00	0.01	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.40	0.00	0.40	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	OTHER		0.04	0.00	0.04	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99915			20.00

		Full Episodes Without Outliers	Full Episodes With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	157	0	8	11	176	21.00
22.00	Skilled Nursing Visit Charges	38,271	0	1,971	2,698	42,940	22.00
23.00	Physical Therapy Visits	147	0	1	5	153	23.00
24.00	Physical Therapy Visit Charges	39,311	0	270	1,309	40,890	24.00
25.00	Occupational Therapy Visits	33	0	0	0	33	25.00
26.00	Occupational Therapy Visit Charges	8,854	0	0	0	8,854	26.00
27.00	Speech Pathology Visits	7	0	0	0	7	27.00
28.00	Speech Pathology Visit Charges	1,857	0	0	0	1,857	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	165	0	0	14	179	31.00
32.00	Home Health Aide Visit Charges	18,573	0	0	1,598	20,171	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	509	0	9	30	548	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	106,866	0	2,241	5,605	114,712	35.00
36.00	Total Number of Episodes (standard/non outlier)	28		4	2	34	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	4,737	0	510	731	5,978	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8 | Date/Time Prepared: 4/19/2021 7:18 am

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	540 HOSPITAL DRIVE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WINIMAC	IN	46996-	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

		Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2019 To 09/30/2020	Worksheet S-8 Date/Time Prepared: 4/19/2021 7:18 am
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8

Component CCN: 15-8527 | Date/Time Prepared: 4/19/2021 7:18 am

RHC II | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	NORTH LANE STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	NORTH JUDSON	IN	46366-1226	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	PULASKI	2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2019 To 09/30/2020	Worksheet S-8 Date/Time Prepared: 4/19/2021 7:18 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	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2019 To 09/30/2020	Worksheet S-8 Date/Time Prepared: 4/19/2021 7:18 am
		RHC III	Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				112 E MONTGOMERY STREET		1.00
			City		State	ZIP Code	
			1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		FRANCESVILLE		IN	47946-8087	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	09:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?						12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		PULASKI				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8

Component CCN: 15-8528 | Date/Time Prepared: 4/19/2021 7:18 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						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8
Component CCN: 15-8554 | Date/Time Prepared: 4/19/2021 7:18 am

RHC IV | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	2 S. PEARL STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KNOX	IN	46534	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	19:00	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		2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2019 To 09/30/2020	Worksheet S-8 Date/Time Prepared: 4/19/2021 7:18 am
		RHC IV	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-10 | Date/Time Prepared: 4/19/2021 7:18 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)	0.548374	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	519,410	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	235,830	5.00
6.00	Medicaid charges	8,174,807	6.00
7.00	Medicaid cost (line 1 times line 6)	4,482,852	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)	3,727,612	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)	3,727,612	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)	80,480	203,706	284,186	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	44,133	203,706	247,839	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)	44,133	203,706	247,839	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)	1,102,203	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	0	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	0	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,102,203	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	604,419	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	852,258	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,579,870	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 4/19/2021 7:18 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		1,545,762	1,545,762	40,213	1,585,975	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,707,515	5,707,515	0	5,707,515	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,685,269	2,486,169	5,171,438	148,682	5,320,120	5.00
7.00	00700	OPERATION OF PLANT	358,199	536,134	894,333	0	894,333	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,156	48,990	55,146	0	55,146	8.00
9.00	00900	HOUSEKEEPING	218,180	101,404	319,584	0	319,584	9.00
10.00	01000	DIETARY	233,017	158,336	391,353	0	391,353	10.00
13.00	01300	NURSING ADMINISTRATION	679,456	199,334	878,790	0	878,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,200	54,227	100,427	0	100,427	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	363,815	48,178	411,993	0	411,993	16.00
17.00	01700	SOCIAL SERVICE	72,805	144	72,949	0	72,949	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,067,184	92,382	2,159,566	107,301	2,266,867	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	33,710	3,196	36,906	32,421	69,327	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	534,561	98,409	632,970	532,778	1,165,748	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,367	4,578	35,945	40,527	76,472	52.00
53.00	05300	ANESTHESIOLOGY	0	535,339	535,339	0	535,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	876,892	521,727	1,398,619	0	1,398,619	54.00
60.00	06000	LABORATORY	691,934	625,877	1,317,811	0	1,317,811	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	50,262	50,262	0	50,262	63.00
65.00	06500	RESPIRATORY THERAPY	357,154	36,609	393,763	0	393,763	65.00
66.00	06600	PHYSICAL THERAPY	956,265	38,371	994,636	0	994,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,909	881	144,790	0	144,790	67.00
68.00	06800	SPEECH PATHOLOGY	70,830	2,198	73,028	0	73,028	68.00
69.00	06900	ELECTROCARDIOLOGY	50	14,433	14,483	0	14,483	69.00
69.01	06901	CARDIAC REHABILITATION	68,182	3,884	72,066	0	72,066	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	520,203	520,203	-151,565	368,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	151,565	151,565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,022	2,073,169	2,163,191	0	2,163,191	73.00
76.00	03020	ONCOLOGY	123,222	27,172	150,394	0	150,394	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	5,115,940	513,084	5,629,024	-943,182	4,685,842	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	648,477	89,207	737,684	53,560	791,244	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	216,021	34,572	250,593	12,016	262,609	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	451,657	98,209	549,866	11,227	561,093	88.03
90.00	09000	CLINIC	79,076	211,475	290,551	0	290,551	90.00
91.00	09100	EMERGENCY	1,066,815	1,345,555	2,412,370	0	2,412,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	100,648	21,427	122,075	-14,856	107,219	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,387,013	17,848,412	36,235,425	20,687	36,256,112	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	249,545	55,294	304,839	11,635	316,474	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	69,853	145,626	215,479	-32,322	183,157	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	18,706,411	18,049,332	36,755,743	0	36,755,743	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 4/19/2021 7:18 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	-19,937	1,566,038	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,707,515	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-944,830	4,375,290	5.00
7.00	00700	OPERATION OF PLANT	-278	894,055	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,146	8.00
9.00	00900	HOUSEKEEPING	0	319,584	9.00
10.00	01000	DIETARY	-61,846	329,507	10.00
13.00	01300	NURSING ADMINISTRATION	-26,558	852,232	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-12,554	87,873	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,750	406,243	16.00
17.00	01700	SOCIAL SERVICE	0	72,949	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-427,524	1,839,343	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	69,327	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-532,778	632,970	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	76,472	52.00
53.00	05300	ANESTHESIOLOGY	-526,514	8,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,398,619	54.00
60.00	06000	LABORATORY	0	1,317,811	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	50,262	63.00
65.00	06500	RESPIRATORY THERAPY	0	393,763	65.00
66.00	06600	PHYSICAL THERAPY	0	994,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	144,790	67.00
68.00	06800	SPEECH PATHOLOGY	0	73,028	68.00
69.00	06900	ELECTROCARDIOLOGY	-4,532	9,951	69.00
69.01	06901	CARDIAC REHABILITATION	0	72,066	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,324	366,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	151,565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-39,451	2,123,740	73.00
76.00	03020	ONCOLOGY	-29,818	120,576	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	-10,768	4,675,074	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	791,244	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	262,609	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	561,093	88.03
90.00	09000	CLINIC	0	290,551	90.00
91.00	09100	EMERGENCY	0	2,412,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	107,219	101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,645,462	33,610,650	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	HOMECARE	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	316,474	192.00
192.01	19201	KNOX RHC	0	0	192.01
194.00	07950	MARKETING	0	183,157	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,645,462	34,110,281	200.00

RECLASSIFICATIONS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-6 | Date/Time Prepared: 4/19/2021 7:18 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	40,213	1.00
	TOTALS		0	40,213	
	B - MARKETING RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	10,478	21,844	1.00
	TOTALS		10,478	21,844	
	C - IMPLANATABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		151,565	1.00
	TOTALS		0	151,565	
	D - PHYSICIAN SALARIES				
1.00	ADULTS & PEDIATRICS	30.00	180,249	0	1.00
2.00	OPERATING ROOM	50.00	532,778	0	2.00
3.00	RURAL HEALTH CLINIC- WINAMAC	88.00	9,367	0	3.00
4.00	RURAL HEALTH CLINIC NORTH JUDSON	88.01	2,896	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	11,635	0	5.00
	TOTALS		736,925	0	
	F - HOME HEALTH BILLER RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	14,856	0	1.00
	TOTALS		14,856	0	
	G - PATIENT ACCOUNTS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	141,717	0	1.00
	TOTALS		141,717	0	
	H - RHC DEPT 175 RECLASS				
1.00	RURAL HEALTH CLINIC NORTH JUDSON	88.01	0	56,780	1.00
2.00	RURAL HEALTH CLINIC FRANCESVILLE	88.02	0	16,429	2.00
3.00	RURAL HEALTH CLINIC KNOX	88.03		11,227	3.00
	TOTALS		0	84,436	
	I - RN SALARIES RECLASS				
1.00	NURSERY	43.00	32,421	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	40,527	0	2.00
	TOTALS		72,948	0	
500.00	Grand Total: Increases		976,924	298,058	500.00

RECLASSIFICATIONS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-6 | Date/Time Prepared: 4/19/2021 7:18 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,213	12	1.00
	TOTALS		0	40,213		
	B - MARKETING RECLASS					
1.00	MARKETING	194.00	10,478	21,844	0	1.00
	TOTALS		10,478	21,844		
	C - IMPLANATABLE DEVICE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		151,565	0	1.00
	TOTALS		0	151,565		
	D - PHYSICIAN SALARIES					
1.00	RURAL HEALTH CLINIC- WINAMAC	88.00	726,396	0	0	1.00
2.00	RURAL HEALTH CLINIC NORTH JUDSON	88.01	6,116	0	0	2.00
3.00	RURAL HEALTH CLINIC FRANCESVILLE	88.02	4,413	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	TOTALS		736,925	0		
	F - HOME HEALTH BILLER RECLASS					
1.00	HOME HEALTH AGENCY	101.00	14,856	0	0	1.00
	TOTALS		14,856	0		
	G - PATIENT ACCOUNTS RECLASS					
1.00	RURAL HEALTH CLINIC- WINAMAC	88.00	141,717	0	0	1.00
	TOTALS		141,717	0		
	H - RHC DEPT 175 RECLASS					
1.00	RURAL HEALTH CLINIC- WINAMAC	88.00	0	84,436	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	84,436		
	I - RN SALARIES RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	72,948	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		72,948	0		
500.00	Grand Total: Decreases		976,924	298,058		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part I Date/Time Prepared: 4/19/2021 7:18 am

		Beginning Balances	Acquisitions Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	195,525	0	0	0	0	1.00
2.00	Land Improvements	432,594	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,253,038	0	0	0	0	3.00
4.00	Building Improvements	187,055	0	0	0	0	4.00
5.00	Fixed Equipment	7,434,636	14,750	0	14,750	0	5.00
6.00	Movable Equipment	8,914,221	432,531	0	432,531	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,417,069	447,281	0	447,281	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	30,417,069	447,281	0	447,281	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	195,525	0	1.00
2.00	Land Improvements	432,594	0	2.00
3.00	Buildings and Fixtures	13,253,038	0	3.00
4.00	Building Improvements	187,055	0	4.00
5.00	Fixed Equipment	7,449,386	0	5.00
6.00	Movable Equipment	9,346,752	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,864,350	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	30,864,350	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part II | Date/Time Prepared: 4/19/2021 7:18 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	1,294,710	0	251,052	0	0	1.00
3.00	Total (sum of lines 1-2)	1,294,710	0	251,052	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,545,762	1.00
3.00	Total (sum of lines 1-2)	0	1,545,762	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part III | Date/Time Prepared: 4/19/2021 7:18 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	30,417,069	0	30,417,069	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	30,417,069	0	30,417,069	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	1,292,943	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,292,943	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	232,882	40,213	0	0	1,566,038	1.00
3.00	Total (sum of lines 1-2)	232,882	40,213	0	0	1,566,038	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8 | Date/Time Prepared: 4/19/2021 7:18 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,021,210			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** 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 - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8 | Date/Time Prepared: 4/19/2021 7:18 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVEST INC/UNRESTRIC- INT EXP	B	-18,170	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01	OTHER NONOPER REV	B	-28	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER SERVICES -OTHER REV	B	-25,003	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	POB/RENT INCOME	B	-6,180	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	CAFETERIA VENDING - OTHER REV	B	-61,846	DIETARY	10.00	0	33.04
33.05	SALE OF SCRAP -OTHER REV	B	-95	CENTRAL SERVICES & SUPPLY	14.00	0	33.05
33.06	REBATES & REFUNDS - OTHER REV	B	-12,459	CENTRAL SERVICES & SUPPLY	14.00	0	33.06
33.07	MEDICAL RECORDS FEES -OTHER REV	B	-5,750	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.08	MED SUPPLY SALES -OTHER REV	B	-2,324	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.08
33.09	EMPLOYEE RX PROGRAM -OTHER REV	B	-39,451	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.10	OTHER REVENUE RHC- OTHER REV	B	-10,768	RURAL HEALTH CLINIC- WINAMAC	88.00	0	33.10
33.11	TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	33.11
33.12	PHYSICIAN RECRUITMENT- ADMIN	A	-9,035	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	LOBBYING EXPENSE	A	-3,355	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	CRNA	A	-526,514	ANESTHESIOLOGY	53.00	0	33.14
33.15	HAF EXPENSE	A	-901,229	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	EHR DEPRECIATION ON 2012 PAYMENT	A	-1,767	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,645,462				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 4/19/2021 7:18 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,232,616	0	1,232,616	0	0	1.00
2.00	60.00	LABORATORY	7,343	0	7,343	0	0	2.00
3.00	90.00	CLINIC	33,750	0	33,750	0	0	3.00
4.00	76.00	ONCOLOGY	29,818	29,818	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	26,558	26,558	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	247,275	247,275	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	4,532	4,532	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	180,249	180,249	0	0	0	8.00
9.00	50.00	OPERATING ROOM	532,778	532,778	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,294,919	1,021,210	1,273,709		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	76.00	ONCOLOGY	0	0	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	91.00	EMERGENCY	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	3.00
4.00	76.00	ONCOLOGY	0	0	0	29,818	4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	26,558	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	247,275	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,532	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	180,249	8.00
9.00	50.00	OPERATING ROOM	0	0	0	532,778	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,021,210	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,566,038	1,566,038				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,707,515	26,732	5,734,247			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,375,290	315,890	874,347	5,565,527	5,565,527	5.00
7.00	00700	OPERATION OF PLANT	894,055	144,568	109,802	1,148,425	223,914	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	55,146	12,652	1,887	69,685	13,587	8.00
9.00	00900	HOUSEKEEPING	319,584	7,755	66,881	394,220	76,863	9.00
10.00	01000	DIETARY	329,507	62,900	71,429	463,836	90,436	10.00
13.00	01300	NURSING ADMINISTRATION	852,232	10,718	208,280	1,071,230	208,863	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,873	18,956	14,162	120,991	23,590	14.00
15.00	01500	PHARMACY	0	16,287	0	16,287	3,176	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	406,243	32,869	111,523	550,635	107,360	16.00
17.00	01700	SOCIAL SERVICE	72,949	1,030	22,318	96,297	18,776	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,839,343	184,645	666,564	2,690,552	524,590	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	69,327	3,384	20,272	92,983	18,129	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	632,970	111,468	327,181	1,071,619	208,939	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	76,472	12,673	22,038	111,183	21,678	52.00
53.00	05300	ANESTHESIOLOGY	8,825	651	0	9,476	1,848	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,398,619	101,149	268,802	1,768,570	344,827	54.00
60.00	06000	LABORATORY	1,317,811	29,191	212,105	1,559,107	303,987	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	50,262	1,282	0	51,544	10,050	63.00
65.00	06500	RESPIRATORY THERAPY	393,763	16,455	109,482	519,700	101,329	65.00
66.00	06600	PHYSICAL THERAPY	994,636	37,177	293,133	1,324,946	258,331	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,790	0	44,114	188,904	36,832	67.00
68.00	06800	SPEECH PATHOLOGY	73,028	0	21,712	94,740	18,472	68.00
69.00	06900	ELECTROCARDIOLOGY	9,951	0	15	9,966	1,943	69.00
69.01	06901	CARDIAC REHABILITATION	72,066	9,415	20,900	102,381	19,962	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	366,314	0	0	366,314	71,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	151,565	0	0	151,565	29,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,123,740	0	27,595	2,151,335	419,457	73.00
76.00	03020	ONCOLOGY	120,576	11,853	37,772	170,201	33,185	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	4,675,074	215,202	1,304,999	6,195,275	1,207,936	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	791,244	0	197,796	989,040	192,838	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	262,609	0	64,866	327,475	63,849	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	561,093	0	138,450	699,543	136,393	88.03
90.00	09000	CLINIC	290,551	38,144	24,240	352,935	68,814	90.00
91.00	09100	EMERGENCY	2,412,370	129,458	327,020	2,868,848	559,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	107,219	4,056	26,299	137,574	26,823	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,610,650	1,556,560	5,635,984	33,502,909	5,447,104	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,478	0	9,478	1,848	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	316,474	0	80,062	396,536	77,315	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	183,157	0	18,201	201,358	39,260	194.00
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)	34,110,281	1,566,038	5,734,247	34,110,281	5,565,527	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,372,339					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,363	95,635				8.00
9.00	00900	HOUSEKEEPING	7,578	0	478,661			9.00
10.00	01000	DIETARY	61,465	0	22,455	638,192		10.00
13.00	01300	NURSING ADMINISTRATION	10,474	0	3,826	0	1,294,393	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,524	0	6,767	0	0	14.00
15.00	01500	PHARMACY	15,916	0	5,814	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,119	0	11,734	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,006	0	368	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	180,432	21,653	65,916	638,192	740,238	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,306	2,276	1,208	0	23,467	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108,925	21,076	39,793	0	165,444	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,383	0	4,524	0	22,669	52.00
53.00	05300	ANESTHESIOLOGY	637	0	233	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,841	16,019	36,109	0	0	54.00
60.00	06000	LABORATORY	28,525	223	10,421	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,253	0	458	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	16,080	0	5,874	0	36,858	65.00
66.00	06600	PHYSICAL THERAPY	48,548	15,551	17,736	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	9,200	0	3,361	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	11,582	37	4,231	0	52,587	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	229,142	1,497	83,711	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	80,174	341	29,289	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	33,721	71	12,319	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	11,049	0	4,036	0	0	88.03
90.00	09000	CLINIC	37,273	0	13,617	0	27,163	90.00
91.00	09100	EMERGENCY	126,504	16,494	46,215	0	225,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,964	0	1,448	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,200,984	95,238	431,463	638,192	1,294,393	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,262	0	3,384	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	162,093	397	43,814	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
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)	1,372,339	95,635	478,661	638,192	1,294,393	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	169,872					14.00
15.00	01500	PHARMACY	0	41,193				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	701,848			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	116,447		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	22,018	108,674	4,992,265	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	1,181	0	142,550	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	56,546	7,773	1,680,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	4,962	0	177,399	52.00
53.00	05300	ANESTHESIOLOGY	0	0	8,313	0	20,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	157,340	0	2,421,706	54.00
60.00	06000	LABORATORY	0	0	132,662	0	2,034,925	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,281	0	65,586	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	11,177	0	691,018	65.00
66.00	06600	PHYSICAL THERAPY	0	0	29,691	0	1,694,803	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,190	0	229,926	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,551	0	114,763	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,625	0	17,534	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	2,319	0	137,223	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,285	0	25,955	0	614,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,587	0	3,189	0	202,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	41,193	106,211	0	2,718,196	73.00
76.00	03020	ONCOLOGY	0	0	5,045	0	276,868	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	0	50,594	0	7,768,155	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	0	7,519	0	1,299,201	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	0	2,579	0	440,014	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	0	3,902	0	854,923	88.03
90.00	09000	CLINIC	0	0	1,356	0	501,158	90.00
91.00	09100	EMERGENCY	0	0	54,221	0	3,897,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,421	0	171,230	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,872	41,193	701,848	116,447	33,165,536	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	23,972	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	680,155	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	240,618	194.00
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)	169,872	41,193	701,848	116,447	34,110,281	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	4,992,265	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	142,550	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	1,680,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	177,399	52.00
53.00	05300	ANESTHESIOLOGY	0	20,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,421,706	54.00
60.00	06000	LABORATORY	0	2,034,925	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	65,586	63.00
65.00	06500	RESPIRATORY THERAPY	0	691,018	65.00
66.00	06600	PHYSICAL THERAPY	0	1,694,803	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	229,926	67.00
68.00	06800	SPEECH PATHOLOGY	0	114,763	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,534	69.00
69.01	06901	CARDIAC REHABILITATION	0	137,223	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	614,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	202,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,718,196	73.00
76.00	03020	ONCOLOGY	0	276,868	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	7,768,155	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	1,299,201	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	440,014	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	854,923	88.03
90.00	09000	CLINIC	0	501,158	90.00
91.00	09100	EMERGENCY	0	3,897,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	171,230	101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,165,536	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,972	190.00
190.01	19001	HOMECARE	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	680,155	192.00
192.01	19201	KNOX RHC	0	0	192.01
194.00	07950	MARKETING	0	240,618	194.00
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	34,110,281	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	26,732	26,732	26,732		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	315,890	315,890	4,076	319,966	5.00
7.00	00700	OPERATION OF PLANT	0	144,568	144,568	512	12,873	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,652	12,652	9	781	8.00
9.00	00900	HOUSEKEEPING	0	7,755	7,755	312	4,419	9.00
10.00	01000	DIETARY	0	62,900	62,900	333	5,199	10.00
13.00	01300	NURSING ADMINISTRATION	0	10,718	10,718	971	12,007	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,956	18,956	66	1,356	14.00
15.00	01500	PHARMACY	0	16,287	16,287	0	183	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,869	32,869	520	6,172	16.00
17.00	01700	SOCIAL SERVICE	0	1,030	1,030	104	1,079	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	184,645	184,645	3,107	30,158	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	3,384	3,384	95	1,042	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	111,468	111,468	1,525	12,012	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,673	12,673	103	1,246	52.00
53.00	05300	ANESTHESIOLOGY	0	651	651	0	106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,149	101,149	1,253	19,824	54.00
60.00	06000	LABORATORY	0	29,191	29,191	989	17,476	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,282	1,282	0	578	63.00
65.00	06500	RESPIRATORY THERAPY	0	16,455	16,455	510	5,825	65.00
66.00	06600	PHYSICAL THERAPY	0	37,177	37,177	1,367	14,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	206	2,117	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	101	1,062	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	112	69.00
69.01	06901	CARDIAC REHABILITATION	0	9,415	9,415	97	1,148	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,699	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	129	24,114	73.00
76.00	03020	ONCOLOGY	0	11,853	11,853	176	1,908	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	215,202	215,202	6,084	69,452	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	0	0	922	11,086	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	0	0	302	3,671	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	0	0	645	7,841	88.03
90.00	09000	CLINIC	0	38,144	38,144	113	3,956	90.00
91.00	09100	EMERGENCY	0	129,458	129,458	1,524	32,157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	4,056	4,056	123	1,542	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,556,560	1,556,560	26,274	313,158	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,478	9,478	0	106	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	373	4,445	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	85	2,257	194.00
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	1,566,038	1,566,038	26,732	319,966	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	157,953					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,423	14,865				8.00
9.00	00900	HOUSEKEEPING	872	0	13,358			9.00
10.00	01000	DIETARY	7,074	0	627	76,133		10.00
13.00	01300	NURSING ADMINISTRATION	1,205	0	107	0	25,008	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,132	0	189	0	0	14.00
15.00	01500	PHARMACY	1,832	0	162	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,697	0	327	0	0	16.00
17.00	01700	SOCIAL SERVICE	116	0	10	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,767	3,364	1,840	76,133	14,302	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	381	354	34	0	453	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,537	3,276	1,110	0	3,196	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,425	0	126	0	438	52.00
53.00	05300	ANESTHESIOLOGY	73	0	6	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,376	2,490	1,008	0	0	54.00
60.00	06000	LABORATORY	3,283	35	291	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	144	0	13	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,851	0	164	0	712	65.00
66.00	06600	PHYSICAL THERAPY	5,588	2,417	495	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1,059	0	94	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1,333	6	118	0	1,016	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	26,375	233	2,336	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	9,228	53	817	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	3,881	11	344	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	1,272	0	113	0	0	88.03
90.00	09000	CLINIC	4,290	0	380	0	525	90.00
91.00	09100	EMERGENCY	14,560	2,564	1,290	0	4,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	456	0	40	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,230	14,803	12,041	76,133	25,008	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,066	0	94	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,657	62	1,223	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
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)	157,953	14,865	13,358	76,133	25,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,699					14.00
15.00	01500	PHARMACY	0	18,464				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	43,585			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,339		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,368	2,183	337,867	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	73	0	5,816	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,513	156	148,793	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	308	0	16,319	52.00
53.00	05300	ANESTHESIOLOGY	0	0	516	0	1,352	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	9,759	0	146,859	54.00
60.00	06000	LABORATORY	0	0	8,242	0	59,507	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	142	0	2,159	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	694	0	26,211	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,845	0	63,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	260	0	2,583	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	96	0	1,259	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	349	0	461	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	144	0	11,957	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,215	0	1,613	0	25,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,484	0	198	0	4,381	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,464	6,599	0	49,306	73.00
76.00	03020	ONCOLOGY	0	0	313	0	16,723	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	0	3,143	0	322,825	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	0	467	0	22,573	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	0	160	0	8,369	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	0	242	0	10,113	88.03
90.00	09000	CLINIC	0	0	84	0	47,492	90.00
91.00	09100	EMERGENCY	0	0	3,369	0	189,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	88	0	6,305	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,699	18,464	43,585	2,339	1,528,192	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	10,744	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	24,760	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	2,342	194.00
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)	22,699	18,464	43,585	2,339	1,566,038	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	337,867		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	5,816		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	148,793		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,319		52.00
53.00	05300	ANESTHESIOLOGY	0	1,352		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	146,859		54.00
60.00	06000	LABORATORY	0	59,507		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,159		63.00
65.00	06500	RESPIRATORY THERAPY	0	26,211		65.00
66.00	06600	PHYSICAL THERAPY	0	63,740		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,583		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,259		68.00
69.00	06900	ELECTROCARDIOLOGY	0	461		69.00
69.01	06901	CARDIAC REHABILITATION	0	11,957		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,934		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,381		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,306		73.00
76.00	03020	ONCOLOGY	0	16,723		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	322,825		88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	22,573		88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	8,369		88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	10,113		88.03
90.00	09000	CLINIC	0	47,492		90.00
91.00	09100	EMERGENCY	0	189,288		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	6,305		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,528,192		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,744		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,760		192.00
192.01	19201	KNOX RHC	0	0		192.01
194.00	07950	MARKETING	0	2,342		194.00
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	1,566,038		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	74,517					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,272	18,706,411				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,031	2,852,320	-5,565,527	28,544,754		5.00
7.00	00700	OPERATION OF PLANT	6,879	358,199	0	1,148,425	66,825	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	602	6,156	0	69,685	602	8.00
9.00	00900	HOUSEKEEPING	369	218,180	0	394,220	369	9.00
10.00	01000	DIETARY	2,993	233,017	0	463,836	2,993	10.00
13.00	01300	NURSING ADMINISTRATION	510	679,456	0	1,071,230	510	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	902	46,200	0	120,991	902	14.00
15.00	01500	PHARMACY	775	0	0	16,287	775	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,564	363,815	0	550,635	1,564	16.00
17.00	01700	SOCIAL SERVICE	49	72,805	0	96,297	49	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,786	2,174,485	0	2,690,552	8,786	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	161	66,131	0	92,983	161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,304	1,067,339	0	1,071,619	5,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	603	71,894	0	111,183	603	52.00
53.00	05300	ANESTHESIOLOGY	31	0	0	9,476	31	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,813	876,892	0	1,768,570	4,813	54.00
60.00	06000	LABORATORY	1,389	691,934	0	1,559,107	1,389	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61	0	0	51,544	61	63.00
65.00	06500	RESPIRATORY THERAPY	783	357,154	0	519,700	783	65.00
66.00	06600	PHYSICAL THERAPY	1,769	956,265	0	1,324,946	2,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	143,909	0	188,904	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	70,830	0	94,740	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	50	0	9,966	0	69.00
69.01	06901	CARDIAC REHABILITATION	448	68,182	0	102,381	448	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	366,314	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	151,565	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	90,022	0	2,151,335	0	73.00
76.00	03020	ONCOLOGY	564	123,222	0	170,201	564	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	10,240	4,257,194	0	6,195,275	11,158	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	645,257	0	989,040	3,904	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	211,608	0	327,475	1,642	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	451,657	0	699,543	538	88.03
90.00	09000	CLINIC	1,815	79,076	0	352,935	1,815	90.00
91.00	09100	EMERGENCY	6,160	1,066,815	0	2,868,848	6,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	193	85,792	0	137,574	193	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,066	18,385,856	-5,565,527	27,937,382	58,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	9,478	451	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	261,180	0	396,536	7,893	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	59,375	0	201,358	0	194.00
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)	1,566,038	5,734,247		5,565,527	1,372,339	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.015849	0.306539		0.194975	20.536311	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		26,732		319,966	157,953	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001429		0.011209	2.363681	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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
			8.00	9.00	10.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,847					8.00
9.00	00900	HOUSEKEEPING	0	63,801				9.00
10.00	01000	DIETARY	0	2,993	100			10.00
13.00	01300	NURSING ADMINISTRATION	0	510	0	71,431		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	902	0	0	2,511,318	14.00
15.00	01500	PHARMACY	0	775	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,564	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	49	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,872	8,786	100	40,850	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	2,614	161	0	1,295	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,208	5,304	0	9,130	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	603	0	1,251	0	52.00
53.00	05300	ANESTHESIOLOGY	0	31	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,399	4,813	0	0	0	54.00
60.00	06000	LABORATORY	256	1,389	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	61	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	783	0	2,034	0	65.00
66.00	06600	PHYSICAL THERAPY	17,862	2,364	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	448	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,236,533	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	274,785	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	42	564	0	2,902	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	1,720	11,158	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	392	3,904	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	81	1,642	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	538	0	0	0	88.03
90.00	09000	CLINIC	0	1,815	0	1,499	0	90.00
91.00	09100	EMERGENCY	18,945	6,160	0	12,470	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	193	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,391	57,510	100	71,431	2,511,318	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	456	5,840	0	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
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)	95,635	478,661	638,192	1,294,393	169,872	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.870620	7.502406	6,381.920000	18.120886	0.067643	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,865	13,358	76,133	25,008	22,699	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.135325	0.209370	761.330000	0.350100	0.009039	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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/19/2021 7:18 am

		Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,479,825			16.00
17.00	01700	SOCIAL SERVICE	0	0	9,888		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,897,267	9,228		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	101,787	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,872,562	660		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	427,596	0		52.00
53.00	05300	ANESTHESIOLOGY	0	716,326	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,559,873	0		54.00
60.00	06000	LABORATORY	0	11,431,428	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	196,527	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	963,157	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,558,495	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	361,059	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	133,650	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	484,664	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	199,785	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,236,533	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	274,785	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	9,152,164	0		73.00
76.00	03020	ONCOLOGY	0	434,697	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	4,359,638	0		88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	647,907	0		88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	222,211	0		88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	336,198	0		88.03
90.00	09000	CLINIC	0	116,821	0		90.00
91.00	09100	EMERGENCY	0	4,672,227	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	122,468	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	60,479,825	9,888		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	HOMECARE	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	KNOX RHC	0	0	0		192.01
194.00	07950	MARKETING	0	0	0		194.00
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)	41,193	701,848	116,447		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	411.930000	0.011605	11.776598		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,464	43,585	2,339		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	184.640000	0.000721	0.236549		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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/19/2021 7:18 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	4,992,265		4,992,265	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	142,550		142,550	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,680,115		1,680,115	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,399		177,399	0	0	52.00
53.00	05300	ANESTHESIOLOGY	20,507		20,507	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,421,706		2,421,706	0	0	54.00
60.00	06000	LABORATORY	2,034,925		2,034,925	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	65,586		65,586	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	691,018	0	691,018	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,694,803	0	1,694,803	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	229,926	0	229,926	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	114,763	0	114,763	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,534		17,534	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	137,223		137,223	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,976		614,976	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,892		202,892	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,718,196		2,718,196	0	0	73.00
76.00	03020	ONCOLOGY	276,868		276,868	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	7,768,155		7,768,155	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	1,299,201		1,299,201	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	440,014		440,014	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	854,923		854,923	0	0	88.03
90.00	09000	CLINIC	501,158		501,158	0	0	90.00
91.00	09100	EMERGENCY	3,897,603		3,897,603	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	748,880		748,880		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	171,230		171,230		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	33,914,416	0	33,914,416	0	0	200.00
201.00		Less Observation Beds	748,880		748,880		0	201.00
202.00		Total (see instructions)	33,165,536	0	33,165,536	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/19/2021 7:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,600,809		1,600,809			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	101,787		101,787			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	701,434	4,171,128	4,872,562	0.344811	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	328,188	99,408	427,596	0.414875	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	98,913	617,413	716,326	0.028628	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	994,994	12,564,879	13,559,873	0.178594	0.000000	54.00
60.00	06000	LABORATORY	1,629,933	9,801,495	11,431,428	0.178011	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	70,891	125,636	196,527	0.333725	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	700,411	262,746	963,157	0.717451	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	312,670	2,245,825	2,558,495	0.662422	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,516	218,543	361,059	0.636810	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,914	110,736	133,650	0.858683	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	20,664	464,000	484,664	0.036178	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	199,785	199,785	0.686853	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	550,188	1,686,345	2,236,533	0.274968	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,382	59,403	274,785	0.738366	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,950,072	5,202,092	9,152,164	0.297000	0.000000	73.00
76.00	03020	ONCOLOGY	4,220	430,477	434,697	0.636922	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	4,359,638	4,359,638			88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	647,907	647,907			88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	222,211	222,211			88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	336,198	336,198			88.03
90.00	09000	CLINIC	0	116,821	116,821	4.289965	0.000000	90.00
91.00	09100	EMERGENCY	194,422	4,477,805	4,672,227	0.834207	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	296,458	296,458	2.526091	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	122,468	122,468			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	11,640,408	48,839,417	60,479,825			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,640,408	48,839,417	60,479,825			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/19/2021 7:18 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
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC- WINAMAC		88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON		88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE		88.02
88.03	08803	RURAL HEALTH CLINIC KNOX		88.03
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,992,265		4,992,265	0	4,992,265	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	142,550		142,550	0	142,550	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,680,115		1,680,115	0	1,680,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,399		177,399	0	177,399	52.00
53.00	05300	ANESTHESIOLOGY	20,507		20,507	0	20,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,421,706		2,421,706	0	2,421,706	54.00
60.00	06000	LABORATORY	2,034,925		2,034,925	0	2,034,925	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	65,586		65,586	0	65,586	63.00
65.00	06500	RESPIRATORY THERAPY	691,018	0	691,018	0	691,018	65.00
66.00	06600	PHYSICAL THERAPY	1,694,803	0	1,694,803	0	1,694,803	66.00
67.00	06700	OCCUPATIONAL THERAPY	229,926	0	229,926	0	229,926	67.00
68.00	06800	SPEECH PATHOLOGY	114,763	0	114,763	0	114,763	68.00
69.00	06900	ELECTROCARDIOLOGY	17,534		17,534	0	17,534	69.00
69.01	06901	CARDIAC REHABILITATION	137,223		137,223	0	137,223	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	614,976		614,976	0	614,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,892		202,892	0	202,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,718,196		2,718,196	0	2,718,196	73.00
76.00	03020	ONCOLOGY	276,868		276,868	0	276,868	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	7,768,155		7,768,155	0	7,768,155	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	1,299,201		1,299,201	0	1,299,201	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	440,014		440,014	0	440,014	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	854,923		854,923	0	854,923	88.03
90.00	09000	CLINIC	501,158		501,158	0	501,158	90.00
91.00	09100	EMERGENCY	3,897,603		3,897,603	0	3,897,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	748,880		748,880		748,880	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	171,230		171,230		171,230	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	33,914,416	0	33,914,416	0	33,914,416	200.00
201.00		Less Observation Beds	748,880		748,880		748,880	201.00
202.00		Total (see instructions)	33,165,536	0	33,165,536	0	33,165,536	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,600,809		1,600,809			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	101,787		101,787			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	701,434	4,171,128	4,872,562	0.344811	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	328,188	99,408	427,596	0.414875	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	98,913	617,413	716,326	0.028628	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	994,994	12,564,879	13,559,873	0.178594	0.000000	54.00
60.00	06000	LABORATORY	1,629,933	9,801,495	11,431,428	0.178011	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	70,891	125,636	196,527	0.333725	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	700,411	262,746	963,157	0.717451	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	312,670	2,245,825	2,558,495	0.662422	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	142,516	218,543	361,059	0.636810	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,914	110,736	133,650	0.858683	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	20,664	464,000	484,664	0.036178	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	199,785	199,785	0.686853	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	550,188	1,686,345	2,236,533	0.274968	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,382	59,403	274,785	0.738366	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,950,072	5,202,092	9,152,164	0.297000	0.000000	73.00
76.00	03020	ONCOLOGY	4,220	430,477	434,697	0.636922	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	4,359,638	4,359,638	1.781835	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	647,907	647,907	2.005228	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	222,211	222,211	1.980163	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	336,198	336,198	2.542915	0.000000	88.03
90.00	09000	CLINIC	0	116,821	116,821	4.289965	0.000000	90.00
91.00	09100	EMERGENCY	194,422	4,477,805	4,672,227	0.834207	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	296,458	296,458	2.526091	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	122,468	122,468			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	11,640,408	48,839,417	60,479,825			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,640,408	48,839,417	60,479,825			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0.000000	88.03
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part II Date/Time Prepared: 4/19/2021 7:18 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	148,793	4,872,562	0.030537	247,588	7,561	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,319	427,596	0.038165	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,352	716,326	0.001887	23,236	44	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146,859	13,559,873	0.010830	391,447	4,239	54.00
60.00	06000	LABORATORY	59,507	11,431,428	0.005206	477,064	2,484	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,159	196,527	0.010986	33,646	370	63.00
65.00	06500	RESPIRATORY THERAPY	26,211	963,157	0.027214	358,603	9,759	65.00
66.00	06600	PHYSICAL THERAPY	63,740	2,558,495	0.024913	99,961	2,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,583	361,059	0.007154	41,839	299	67.00
68.00	06800	SPEECH PATHOLOGY	1,259	133,650	0.009420	3,134	30	68.00
69.00	06900	ELECTROCARDIOLOGY	461	484,664	0.000951	16,917	16	69.00
69.01	06901	CARDIAC REHABILITATION	11,957	199,785	0.059849	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,934	2,236,533	0.011596	178,709	2,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,381	274,785	0.015943	87,836	1,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,306	9,152,164	0.005387	958,325	5,162	73.00
76.00	03020	ONCOLOGY	16,723	434,697	0.038470	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	322,825	4,359,638	0.074049	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	22,573	647,907	0.034840	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	8,369	222,211	0.037662	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	10,113	336,198	0.030080	0	0	88.03
90.00	09000	CLINIC	47,492	116,821	0.406536	0	0	90.00
91.00	09100	EMERGENCY	189,288	4,672,227	0.040513	44,472	1,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	50,683	296,458	0.170962	0	0	92.00
200.00		Total (lines 50 through 199)	1,228,887	58,654,761		2,962,777	37,728	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/19/2021 7:18 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/19/2021 7:18 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	4,872,562	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	427,596	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	716,326	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,559,873	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	11,431,428	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	196,527	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	963,157	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,558,495	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	361,059	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	133,650	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	484,664	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	199,785	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,236,533	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	274,785	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,152,164	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	434,697	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0	0	0	4,359,638	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0	0	0	647,907	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0	0	0	222,211	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0	0	0	336,198	0.000000	88.03
90.00	09000	CLINIC	0	0	0	116,821	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	4,672,227	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	296,458	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	58,654,761		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/19/2021 7:18 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	247,588	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	23,236	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	391,447	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	477,064	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	33,646	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	358,603	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	99,961	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	41,839	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,134	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,917	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	178,709	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	87,836	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	958,325	0	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	44,472	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,962,777	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part V Date/Time Prepared: 4/19/2021 7:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.344811	0	1,289,592	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.414875	0	153	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028628	0	188,135	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178594	0	4,083,607	0	0	54.00
60.00	06000	LABORATORY	0.178011	0	3,649,680	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.333725	0	46,785	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.717451	0	86,705	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.662422	0	854,887	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.636810	0	69,826	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.858683	0	2,790	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036178	0	171,456	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.686853	0	95,014	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274968	0	464,797	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.738366	0	50,715	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.297000	0	2,658,573	84	0	73.00
76.00	03020	ONCOLOGY	0.636922	0	173,829	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC- WINAMAC						88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON						88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE						88.02
88.03	08803	RURAL HEALTH CLINIC KNOX						88.03
90.00	09000	CLINIC	4.289965	0	116,745	0	0	90.00
91.00	09100	EMERGENCY	0.834207	0	1,230,462	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.526091	0	102,791	0	0	92.00
200.00		Subtotal (see instructions)		0	15,336,542	84	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	15,336,542	84	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 4/19/2021 7:18 am
	Title XVIII	Hospital	Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	444,666	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63	0	52.00
53.00	05300	ANESTHESIOLOGY	5,386	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	729,308	0	54.00
60.00	06000	LABORATORY	649,683	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,613	0	63.00
65.00	06500	RESPIRATORY THERAPY	62,207	0	65.00
66.00	06600	PHYSICAL THERAPY	566,296	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,466	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,396	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,203	0	69.00
69.01	06901	CARDIAC REHABILITATION	65,261	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,804	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,446	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	789,596	25	73.00
76.00	03020	ONCOLOGY	110,716	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC- WINAMAC			88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON			88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE			88.02
88.03	08803	RURAL HEALTH CLINIC KNOX			88.03
90.00	09000	CLINIC	500,832	0	90.00
91.00	09100	EMERGENCY	1,026,460	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	259,659	0	92.00
200.00		Subtotal (see instructions)	5,444,061	25	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,444,061	25	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1305	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/19/2021 7:18 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,696	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,376	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	131	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)	298	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	25	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)	124	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	761	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)	131	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)	298	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,992,265	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)	3,229	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)	16,013	25.00
26.00	Total swing-bed cost (see instructions)	1,023,209	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,969,056	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,969,056	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)	2,340.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,780,930	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,780,930	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/19/2021 7:18 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)	1,041,256	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,822,186	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)	306,573	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	697,395	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,003,968	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)	320	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,340.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	748,880	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/19/2021 7:18 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	337,867	4,992,265	0.067678	748,880	50,683	90.00
91.00	Nursing School cost	0	4,992,265	0.000000	748,880	0	91.00
92.00	Allied health cost	0	4,992,265	0.000000	748,880	0	92.00
93.00	All other Medical Education	0	4,992,265	0.000000	748,880	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,696	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,376	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	429	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	149	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	26	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	146	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,992,265	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,007,850	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,984,415	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,984,415	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)	2,349.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	61,082	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)	61,082	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	142,550	146	976.37	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)	38,426	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	99,508	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	320	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,349.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	751,776	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	337,867	4,992,265	0.067678	751,776	50,879	90.00
91.00	Nursing School cost	0	4,992,265	0.000000	751,776	0	91.00
92.00	Allied health cost	0	4,992,265	0.000000	751,776	0	92.00
93.00	All other Medical Education	0	4,992,265	0.000000	751,776	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 4/19/2021 7:18 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		764,934		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	0.344811	247,588	85,371	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.414875	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028628	23,236	665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178594	391,447	69,910	54.00
60.00	06000	LABORATORY	0.178011	477,064	84,923	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.333725	33,646	11,229	63.00
65.00	06500	RESPIRATORY THERAPY	0.717451	358,603	257,280	65.00
66.00	06600	PHYSICAL THERAPY	0.662422	99,961	66,216	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.636810	41,839	26,643	67.00
68.00	06800	SPEECH PATHOLOGY	0.858683	3,134	2,691	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036178	16,917	612	69.00
69.01	06901	CARDIAC REHABILITATION	0.686853	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274968	178,709	49,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.738366	87,836	64,855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.297000	958,325	284,623	73.00
76.00	03020	ONCOLOGY	0.636922	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0.000000		0	88.03
90.00	09000	CLINIC	4.289965	0	0	90.00
91.00	09100	EMERGENCY	0.834207	44,472	37,099	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.526091	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,962,777	1,041,256	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,962,777		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 4/19/2021 7:18 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	0.344811	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.414875	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028628	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178594	24,642	4,401	54.00
60.00	06000	LABORATORY	0.178011	51,335	9,138	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.333725	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.717451	88,677	63,621	65.00
66.00	06600	PHYSICAL THERAPY	0.662422	126,698	83,928	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.636810	62,004	39,485	67.00
68.00	06800	SPEECH PATHOLOGY	0.858683	730	627	68.00
69.00	06900	ELECTROCARDIOLOGY	0.036178	190	7	69.00
69.01	06901	CARDIAC REHABILITATION	0.686853	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274968	28,568	7,855	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.738366	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.297000	112,861	33,520	73.00
76.00	03020	ONCOLOGY	0.636922	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0.000000		0	88.03
90.00	09000	CLINIC	4.289965	0	0	90.00
91.00	09100	EMERGENCY	0.834207	3,378	2,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.526091	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		499,083	245,400	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)		499,083		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 Date/Time Prepared: 4/19/2021 7:18 am

		Title XIX	Hospital	Cost	
	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		18,106		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY		10,513		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.344811	11,084	3,822	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.414875	19,449	8,069	52.00
53.00	05300 ANESTHESIOLOGY	0.028628	2,739	78	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.178594	7,864	1,404	54.00
60.00	06000 LABORATORY	0.178011	26,557	4,727	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.333725	525	175	63.00
65.00	06500 RESPIRATORY THERAPY	0.717451	3,978	2,854	65.00
66.00	06600 PHYSICAL THERAPY	0.662422	358	237	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.636810	112	71	67.00
68.00	06800 SPEECH PATHOLOGY	0.858683	1,615	1,387	68.00
69.00	06900 ELECTROCARDIOLOGY	0.036178	243	9	69.00
69.01	06901 CARDIAC REHABILITATION	0.686853	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274968	11,181	3,074	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.738366	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.297000	26,878	7,983	73.00
76.00	03020 ONCOLOGY	0.636922	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC- WINAMAC	1.781835	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC NORTH JUDSON	2.005228	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC FRANCESVILLE	1.980163	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC KNOX	2.542915	0	0	88.03
90.00	09000 CLINIC	4.289965	0	0	90.00
91.00	09100 EMERGENCY	0.834207	5,438	4,536	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.526091	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		118,021	38,426	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)		118,021		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Swing Beds - SNF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC- WINAMAC	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC NORTH JUDSON	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC FRANCESVILLE	0.000000	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC KNOX	0.000000	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E Part B | Date/Time Prepared: 4/19/2021 7:18 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,444,086	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)	5,444,086	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)	5,498,527	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)	59,224	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,348,706	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,090,597	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,090,597	30.00
31.00	Primary payer payments	1,337	31.00
32.00	Subtotal (line 30 minus line 31)	3,089,260	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,089,260	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,089,260	40.00
40.01	Sequestration adjustment (see instructions)	35,835	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	2,377,091	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)	676,334	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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-1 Part I Date/Time Prepared: 4/19/2021 7:18 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,833,392		2,377,091	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	03/31/2020	115,100		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		115,100		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,948,492		2,377,091	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		654,507		676,334	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,602,999		3,053,425	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: 15-1305
Component CCN: 15-Z305

Period: From 10/01/2019 To 09/30/2020

Worksheet E-1 Part I
Date/Time Prepared: 4/19/2021 7:18 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		795,215		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	03/31/2020	48,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		48,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		844,115		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		388,236		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,232,351		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: 15-1305	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/19/2021 7:18 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: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-2 | Date/Time Prepared: 4/19/2021 7:18 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,014,008	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)	247,854	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	429	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,261,862	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,261,862	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,261,862	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,048	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,246,814	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,246,814	0	19.00
19.01	Sequestration adjustment (see instructions)	14,463	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	844,115	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)	388,236	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 - SWING BEDS

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-2 | Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Swing Beds - SNF | PPS

		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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	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)	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		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: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-3 Part V Date/Time Prepared: 4/19/2021 7:18 am

		Title XVIII	Hospital	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,822,186	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			2,822,186	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,850,408	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,850,408	19.00
20.00	Deductibles (exclude professional component)			216,860	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,633,548	22.00
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			2,633,548	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,633,548	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29.50
29.99	Demonstration payment adjustment amount before sequestration			0	29.99
30.00	Subtotal (see instructions)			2,633,548	30.00
30.01	Sequestration adjustment (see instructions)			30,549	30.01
30.02	Demonstration payment adjustment amount after sequestration			0	30.02
30.03	Sequestration adjustment-PARHM				30.03
31.00	Interim payments			1,948,492	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)			654,507	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)				33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-3 Part VII Date/Time Prepared: 4/19/2021 7:18 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	99,508		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	99,508	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	99,508	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	28,618		8.00
9.00	Ancillary service charges	118,021	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	146,639	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	146,639	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	47,131	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	99,508	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	99,508	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	99,508	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	99,508	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	99,508	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	99,508	0	40.00
41.00	Interim payments	82,236	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	17,272	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G | Date/Time Prepared: 4/19/2021 7:18 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	9,253,988	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,821,678	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,488,759	0	0	0	6.00
7.00	Inventory	537,857	0	0	0	7.00
8.00	Prepaid expenses	25,878	0	0	0	8.00
9.00	Other current assets	2,695,386	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,846,028	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	195,525	0	0	0	12.00
13.00	Land improvements	432,594	0	0	0	13.00
14.00	Accumulated depreciation	-402,293	0	0	0	14.00
15.00	Buildings	13,253,038	0	0	0	15.00
16.00	Accumulated depreciation	-8,313,997	0	0	0	16.00
17.00	Leasehold improvements	187,055	0	0	0	17.00
18.00	Accumulated depreciation	-188,997	0	0	0	18.00
19.00	Fixed equipment	7,449,386	0	0	0	19.00
20.00	Accumulated depreciation	-5,997,690	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,346,752	0	0	0	23.00
24.00	Accumulated depreciation	-8,431,373	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)	7,530,000	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	6,225,710	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,225,710	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,601,738	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	643,073	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,593,561	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	549,418	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	577,214	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,363,266	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,740,144	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,201,660	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,941,804	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,305,070	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,296,668				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	22,296,668	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,601,738	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-1 | Date/Time Prepared: 4/19/2021 7:18 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		12,081,633		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,215,035				2.00
3.00	Total (sum of line 1 and line 2)		22,296,668		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,296,668		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)		22,296,668		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/19/2021 7:18 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,702,596		1,702,596	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)	1,702,596		1,702,596	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,702,596		1,702,596	17.00
18.00	Ancillary services	9,743,389	38,259,908	48,003,297	18.00
19.00	Outpatient services	194,422	4,891,084	5,085,506	19.00
20.00	RURAL HEALTH CLINIC- WINAMAC	0	4,359,638	4,359,638	20.00
20.01	RURAL HEALTH CLINIC NORTH JUDSON	0	647,907	647,907	20.01
20.02	RURAL HEALTH CLINIC FRANCESVILLE	0	222,211	222,211	20.02
20.03	RURAL HEALTH CLINIC KNOX	0	336,198	336,198	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		122,468	122,468	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	NON-PROVIDER BASED	0	162,216	162,216	27.00
27.01	PHYSICIAN FEES	0	335,703	335,703	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,640,407	49,337,333	60,977,740	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,755,743		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)		36,755,743		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-3 | Date/Time Prepared: 4/19/2021 7:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	60,977,740	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,331,307	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,646,433	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,755,743	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,109,310	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	12,133,352	24.00
24.01	RENTAL INCOME	34,691	24.01
24.02	NON OPERATING	109,188	24.02
24.50	COVID-19 PHE Funding	6,047,114	24.50
25.00	Total other income (sum of lines 6-24)	18,324,345	25.00
26.00	Total (line 5 plus line 25)	10,215,035	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)	10,215,035	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1305 | HHA CCN: 15-7078

Period: From 10/01/2019 To 09/30/2020

Worksheet H

Date/Time Prepared: 4/19/2021 7:18 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	30,337	0	0	0	21,427	51,764	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	42,002	0	0	0	0	42,002	6.00
7.00	Physical Therapy	10,001	0	0	0	0	10,001	7.00
8.00	Occupational Therapy	2,455	0	0	0	0	2,455	8.00
9.00	Speech Pathology	659	0	0	0	0	659	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	15,194	0	0	0	0	15,194	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	100,648	0	0	0	21,427	122,075	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	-14,856	36,908	0	36,908	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	42,002	0	42,002	6.00
7.00	Physical Therapy	0	10,001	0	10,001	7.00
8.00	Occupational Therapy	0	2,455	0	2,455	8.00
9.00	Speech Pathology	0	659	0	659	9.00
10.00	Medical Social Services	0	0	0	0	10.00
11.00	Home Health Aide	0	15,194	0	15,194	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	-14,856	107,219	0	107,219	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-1 Part I | Date/Time Prepared: 4/19/2021 7:18 am

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	36,908	0	0	0	0	36,908	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	42,002	0	0	0	0	42,002	6.00
7.00	Physical Therapy	10,001	0	0	0	0	10,001	7.00
8.00	Occupational Therapy	2,455	0	0	0	0	2,455	8.00
9.00	Speech Pathology	659	0	0	0	0	659	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	15,194	0	0	0	0	15,194	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	107,219	0	0	0	0	107,219	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	36,908		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	22,047	64,049	6.00
7.00	Physical Therapy	5,250	15,251	7.00
8.00	Occupational Therapy	1,289	3,744	8.00
9.00	Speech Pathology	346	1,005	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	7,976	23,170	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		107,219	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-1 Part II | Date/Time Prepared: 4/19/2021 7:18 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-36,908	70,311	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	42,002	6.00
7.00	Physical Therapy	0	0	0	0	0	10,001	7.00
8.00	Occupational Therapy	0	0	0	0	0	2,455	8.00
9.00	Speech Pathology	0	0	0	0	0	659	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	15,194	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-36,908	70,311	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		36,908	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.524925	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-2 Part I | Date/Time Prepared: 4/19/2021 7:18 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	4,056	26,299	30,355	5,918	3,964	1.00
2.00	Skilled Nursing Care	64,049	0	0	64,049	12,488	0	2.00
3.00	Physical Therapy	15,251	0	0	15,251	2,974	0	3.00
4.00	Occupational Therapy	3,744	0	0	3,744	730	0	4.00
5.00	Speech Pathology	1,005	0	0	1,005	196	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	23,170	0	0	23,170	4,517	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	107,219	4,056	26,299	137,574	26,823	3,964	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		8.00	9.00	10.00	13.00	14.00	15.00	
1.00	Administrative and General	0	1,448	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	1,448	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-2 Part I | Date/Time Prepared: 4/19/2021 7:18 am

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	1,421	0	43,106	0	43,106		1.00
2.00	Skilled Nursing Care	0	0	76,537	0	76,537	25,750	2.00
3.00	Physical Therapy	0	0	18,225	0	18,225	6,132	3.00
4.00	Occupational Therapy	0	0	4,474	0	4,474	1,505	4.00
5.00	Speech Pathology	0	0	1,201	0	1,201	404	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	27,687	0	27,687	9,315	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,421	0	171,230	0	171,230	43,106	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.336440	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	102,287	2.00
3.00	Physical Therapy	24,357	3.00
4.00	Occupational Therapy	5,979	4.00
5.00	Speech Pathology	1,605	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	37,002	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	171,230	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1305 | HHA CCN: 15-7078

Period: From 10/01/2019 To 09/30/2020

Worksheet H-2 Part II

Date/Time Prepared: 4/19/2021 7:18 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	193	85,792	0	30,355	193	0	1.00
2.00	Skilled Nursing Care	0	0	0	64,049	0	0	2.00
3.00	Physical Therapy	0	0	0	15,251	0	0	3.00
4.00	Occupational Therapy	0	0	0	3,744	0	0	4.00
5.00	Speech Pathology	0	0	0	1,005	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	23,170	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	193	85,792		137,574	193	0	20.00
21.00	Total cost to be allocated	4,056	26,299		26,823	3,964	0	21.00
22.00	Unit cost multiplier	21.015544	0.306544		0.194971	20.538860	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	193	0	0	0	0	122,468	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	193	0	0	0	0	122,468	20.00
21.00	Total cost to be allocated	1,448	0	0	0	0	1,421	21.00
22.00	Unit cost multiplier	7.502591	0.000000	0.000000	0.000000	0.000000	0.011603	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-1305 HHA CCN: 15-7078	Period: From 10/01/2019 To 09/30/2020	Worksheet H-2 Part II Date/Time Prepared: 4/19/2021 7:18 am
		Home Health Agency I	PPS

	Cost Center Description	SOCIAL SERVICE (ALLOCATION OF TIME)	
		17.00	
1.00	Administrative and General	0	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19)	0	20.00
21.00	Total cost to be allocated	0	21.00
22.00	Unit cost multiplier	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-3 Part I | Date/Time Prepared: 4/19/2021 7:18 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	102,287		102,287	275	371.95	1.00
2.00	Physical Therapy	3.00	24,357	0	24,357	167	145.85	2.00
3.00	Occupational Therapy	4.00	5,979	0	5,979	41	145.83	3.00
4.00	Speech Pathology	5.00	1,605	0	1,605	11	145.91	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	37,002		37,002	233	158.81	6.00
7.00	Total (sum of lines 1-6)		171,230	0	171,230	727		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	176			8.00
9.00	Physical Therapy		99915	0	153			9.00
10.00	Occupational Therapy		99915	0	33			10.00
11.00	Speech Pathology		99915	0	7			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	179			13.00
14.00	Total (sum of lines 8-13)			0	548			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	176		0	65,463		1.00
2.00	Physical Therapy	0	153		0	22,315		2.00
3.00	Occupational Therapy	0	33		0	4,812		3.00
4.00	Speech Pathology	0	7		0	1,021		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	179		0	28,427		6.00
7.00	Total (sum of lines 1-6)	0	548		0	122,038		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-3 Part I | Date/Time Prepared: 4/19/2021 7:18 am

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	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges Part A	Program Covered Charges Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	5,978	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	65,463	1.00
2.00	Physical Therapy	22,315	2.00
3.00	Occupational Therapy	4,812	3.00
4.00	Speech Pathology	1,021	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	28,427	6.00
7.00	Total (sum of lines 1-6)	122,038	7.00

	Cost Center Description	12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1305
HHA CCN: 15-7078

Period:
From 10/01/2019
To 09/30/2020

Worksheet H-3
Part II
Date/Time Prepared:
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Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.662422	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.636810	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.858683	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.274968	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.297000	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-4 Part I-II | Date/Time Prepared: 4/19/2021 7:18 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	72,107	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	1,409	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,900	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	76,416	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	76,416	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	76,416	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	76,416	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	76,416	31.00
31.01	Sequestration adjustment (see instructions)	0	1,528	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	74,888	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1305 | HHA CCN: 15-7078 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-5 | Date/Time Prepared: 4/19/2021 7:18 am

Home Health Agency I | PPS

		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		0		74,888	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		74,888	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		74,888	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/19/2021 7:18 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	2,236,813	28,786	2,265,599	0	2,265,599	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	679,191	71,716	750,907	0	750,907	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	334,996	0	334,996	0	334,996	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	604,117	0	604,117	0	604,117	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,855,117	100,502	3,955,619	0	3,955,619	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	39,321	39,321	0	39,321	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	39,321	39,321	0	39,321	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,855,117	139,823	3,994,940	0	3,994,940	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	189,032	189,032	0	189,032	29.00
30.00	Administrative Costs	402,078	99,792	501,870	0	501,870	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	402,078	288,824	690,902	0	690,902	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,257,195	428,647	4,685,842	0	4,685,842	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1

Component CCN: 15-8512 | Date/Time Prepared: 4/19/2021 7:18 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	2,265,599	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	750,907	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	334,996	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	604,117	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,955,619	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	39,321	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	39,321	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,994,940	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	189,032	29.00
30.00	Administrative Costs	-10,768	491,102	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-10,768	680,134	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-10,768	4,675,074	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1

Component CCN: 15-8527 | Date/Time Prepared: 4/19/2021 7:18 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	280,516	11,000	291,516	0	291,516	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	164,620	15,271	179,891	0	179,891	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	105,675	0	105,675	0	105,675	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	30,642	0	30,642	0	30,642	9.00
10.00	Subtotal (sum of lines 1 through 9)	581,453	26,271	607,724	0	607,724	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	11,897	11,897	0	11,897	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	11,897	11,897	0	11,897	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	581,453	38,168	619,621	0	619,621	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	38,244	38,244	0	38,244	29.00
30.00	Administrative Costs	63,803	69,576	133,379	0	133,379	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	63,803	107,820	171,623	0	171,623	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	645,256	145,988	791,244	0	791,244	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/19/2021 7:18 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	291,516	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	179,891	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	105,675	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	30,642	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	607,724	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	11,897	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	11,897	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	619,621	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	38,244	29.00
30.00	Administrative Costs	0	133,379	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	171,623	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	791,244	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1

Component CCN: 15-8528 | Date/Time Prepared: 4/19/2021 7:18 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	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	112,838	13,786	126,624	0	126,624	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	71,475	0	71,475	0	71,475	9.00
10.00	Subtotal (sum of lines 1 through 9)	184,313	13,786	198,099	0	198,099	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	5,423	5,423	0	5,423	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	5,423	5,423	0	5,423	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	184,313	19,209	203,522	0	203,522	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	7,215	7,215	0	7,215	29.00
30.00	Administrative Costs	43,724	8,148	51,872	0	51,872	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,724	15,363	59,087	0	59,087	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	228,037	34,572	262,609	0	262,609	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1
Component CCN: 15-8528 | Date/Time Prepared: 4/19/2021 7:18 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	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	126,624	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	71,475	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	198,099	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	5,423	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	5,423	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	203,522	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	7,215	29.00
30.00	Administrative Costs	0	51,872	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	59,087	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	262,609	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1
Component CCN: 15-8554 | Date/Time Prepared: 4/19/2021 7:18 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	240,887	11,250	252,137	0	252,137	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	91,910	10,786	102,696	0	102,696	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	56,913	0	56,913	0	56,913	9.00
10.00	Subtotal (sum of lines 1 through 9)	389,710	22,036	411,746	0	411,746	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)	389,710	22,036	411,746	0	411,746	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	24,451	24,451	0	24,451	29.00
30.00	Administrative Costs	61,948	51,720	113,668	11,228	124,896	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	61,948	76,171	138,119	11,228	149,347	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	451,658	98,207	549,865	11,228	561,093	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/19/2021 7:18 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	252,137	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	102,696	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	56,913	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	411,746	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	411,746	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	24,451	29.00
30.00	Administrative Costs	0	124,896	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	149,347	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	561,093	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2019 To 09/30/2020	Worksheet M-2 Date/Time Prepared: 4/19/2021 7:18 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	4.92	12,366	4,200	20,664		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	6.00	9,204	2,100	12,600		3.00
4.00	Subtotal (sum of lines 1 through 3)	10.92	21,570		33,264	33,264	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)	10.92	21,570			33,264	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)	3,994,940	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	3,994,940	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	680,134	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	3,093,081	15.00
16.00	Total overhead (sum of lines 14 and 15)	3,773,215	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	3,773,215	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	3,773,215	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	7,768,155	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-2 | Date/Time Prepared: 4/19/2021 7:18 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	0.94	3,349	4,200	3,948		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.33	1,410	2,100	2,793		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.27	4,759		6,741	6,741	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)	2.27	4,759			6,741	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)	619,621	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	619,621	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	171,623	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	507,957	15.00
16.00	Total overhead (sum of lines 14 and 15)	679,580	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	679,580	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	679,580	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,299,201	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-2 | Date/Time Prepared: 4/19/2021 7:18 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.64	1,377	2,100	1,344		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.64	1,377		1,344	1,377	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)	0.64	1,377			1,377	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)	203,522	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	203,522	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	59,087	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	177,405	15.00
16.00	Total overhead (sum of lines 14 and 15)	236,492	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	236,492	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	236,492	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	440,014	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2019 To 09/30/2020	Worksheet M-2 Date/Time Prepared: 4/19/2021 7:18 am
		RHC IV	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.68	515	4,200	2,856		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.67	426	2,100	1,407		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.35	941		4,263	4,263	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)	1.35	941			4,263	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)	411,746	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	411,746	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	149,347	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	293,830	15.00
16.00	Total overhead (sum of lines 14 and 15)	443,177	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	443,177	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	443,177	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	854,923	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/19/2021 7:18 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)		7,768,155	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		131,930	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		7,636,225	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		33,264	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)		33,264	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		229.56	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	229.56	229.56	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,288	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,213,913	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	9	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	2,066	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	2,066	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,215,979	16.00
16.01	Total program charges (see instructions)(from contractor's records)		721,154	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		24,108	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		40,650	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.)		861,244	16.04
16.05	Total program cost (see instructions)	0	901,894	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		98,774	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		118,800	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		901,894	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		48,888	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		950,782	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)		950,782	26.00
26.01	Sequestration adjustment (see instructions)		11,029	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		963,381	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)		-23,628	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: 15-1305 Component CCN: 15-8527	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/19/2021 7:18 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)		1,299,201	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		46,962	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,252,239	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,741	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)		6,741	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		185.76	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	185.76	185.76	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,791	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	332,696	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	332,696	16.00
16.01	Total program charges (see instructions)(from contractor's records)		225,293	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,854	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,552	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.)		230,082	16.04
16.05	Total program cost (see instructions)	0	244,634	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,542	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		36,842	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		244,634	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,939	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		272,573	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)		272,573	26.00
26.01	Sequestration adjustment (see instructions)		3,162	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		332,989	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)		-63,578	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: 15-1305 Component CCN: 15-8528	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/19/2021 7:18 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)		440,014	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		23,268	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		416,746	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,377	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)		1,377	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		302.65	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	302.65	302.65	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	360	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	108,954	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	108,954	16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,000	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,435	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,907	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.)		62,850	16.04
16.05	Total program cost (see instructions)	0	86,757	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,484	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,416	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		86,757	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		15,751	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		102,508	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)		102,508	26.00
26.01	Sequestration adjustment (see instructions)		1,189	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		84,460	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)		16,859	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: 15-1305 Component CCN: 15-8554	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/19/2021 7:18 am
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		854,923	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		854,923	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,263	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)		4,263	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		200.54	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	200.54	200.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	271	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	54,346	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	54,346	16.00
16.01	Total program charges (see instructions)(from contractor's records)		34,383	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,990	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,145	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.)		39,726	16.04
16.05	Total program cost (see instructions)	0	42,871	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,543	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,170	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		42,871	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		42,871	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)		42,871	26.00
26.01	Sequestration adjustment (see instructions)		497	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		35,512	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		6,862	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: 15-1305 Component CCN: 15-8512	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/19/2021 7:18 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)	3,955,619	3,955,619	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000882	0.002691	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,489	10,645	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	38,319	15,396	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	41,808	26,041	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,994,940	3,994,940	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,773,215	3,773,215	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010465	0.006518	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	39,487	24,594	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	81,295	50,635	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	232	708	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	350.41	71.52	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	74	321	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	25,930	22,958	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)		131,930	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)		48,888	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/19/2021 7:18 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)	607,724	607,724	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001893	0.006767	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,150	4,112	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	11,993	5,142	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	13,143	9,254	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	619,621	619,621	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	679,580	679,580	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.021211	0.014935	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	14,415	10,150	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	27,558	19,404	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	73	261	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	377.51	74.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	49	127	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	18,498	9,441	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)		46,962	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		27,939	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/19/2021 7:18 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)	198,099	198,099	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002686	0.005778	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	532	1,145	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,238	2,847	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,770	3,992	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	203,522	203,522	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	236,492	236,492	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.033264	0.019615	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,867	4,639	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	14,637	8,631	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	33	71	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	443.55	121.56	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	24	42	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	10,645	5,106	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)		23,268	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)		15,751	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/19/2021 7:18 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		963,381	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)		963,381	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		23,628	6.02
7.00	Total Medicare program liability (see instructions)		939,753	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: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-5 | Date/Time Prepared: 4/19/2021 7:18 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		332,989	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)		332,989	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		63,578	6.02
7.00	Total Medicare program liability (see instructions)		269,411	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: 15-1305 Component CCN: 15-8528	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/19/2021 7:18 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		84,460	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)		84,460	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		16,859	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		101,319	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: 15-1305 Component CCN: 15-8554	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/19/2021 7:18 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		35,512	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		35,512	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		6,862	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		42,374	7.00

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