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: 15-1319	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/28/2021 8:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 4/28/2021 Time: 8:15 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 GIBSON GENERAL HOSPITAL (15-1319) 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) RICK HARNING
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	508,322	165,180	0	26,581	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	1,107,582	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	FORT BRANCH RHC I	0		16,400		0	10.00
10.01	CLARK & WELLS RHC II	0		48,805		0	10.01
200.00	Total	0	1,615,904	230,385	0	26,581	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1319	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 8:15 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1800 SHERMAN DRIVE	PO Box:			1.00
2.00	City: PRINCETON	State: IN	Zip Code: 47670-	County: GIBSON	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	GIBSON GENERAL HOSPITAL	151319	99915	1	12/16/2003	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	GIBSON GENERAL SWING BED	15Z319	99915		12/16/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GIBSON HOME HEALTH	157445	99915		10/19/1995	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	GIBSON GENERAL FAMILY MEDICINE FORT	158524	99915		09/11/2017	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	GIBSON GENERAL FAMILY MEDICINE- 510	158553	99915		05/29/2019	N	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 4/28/2021 8:15 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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 8:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 8:15 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 4/28/2021 8:15 am

		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

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				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	51,445	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		Y			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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 8:15 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)	Y	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1319	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 8:15 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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part II | Date/Time Prepared: 4/28/2021 8:15 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	02/19/2021	Y	02/19/2021	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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part II Date/Time Prepared: 4/28/2021 8:15 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AUSTIN		FISHER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-275-7438		AFISHER@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1319	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/28/2021 8:15 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2021 8:15 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	20	7,320	17,496.00	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)		20	7,320	17,496.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,830	1,848.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	19,344.00	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	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	FORT BRANCH RHC	88.00				0	26.00
26.01	CLARK & WELLS RHC	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2021 8:15 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)	373	18	729			1.00
2.00	HMO and other (see instructions)	0	44				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	1,055	0	1,055			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	626			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,428	18	2,410			7.00
8.00	INTENSIVE CARE UNIT	22	0	77			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,450	18	2,487	0.00	209.77	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,476	173	5,498	0.00	7.30	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	FORT BRANCH RHC	234	355	1,762	0.00	3.06	26.00
26.01	CLARK & WELLS RHC	416	291	1,832	0.00	2.48	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	222.61	27.00
28.00	Observation Bed Days		0	705			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2021 8:15 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	123	4	227	1.00
2.00	HMO and other (see instructions)			0	17		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	123	4	227	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	FORT BRANCH RHC	0.00					26.00
26.01	CLARK & WELLS RHC	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 15-1319
Component CCN: 15-7445

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

Worksheet S-4
Date/Time Prepared: 4/28/2021 8:15 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	140.00	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)		1.09	0.00	1.09	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		3.80	0.00	3.80	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.96	0.00	0.96	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.34	0.00	0.34	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.10	0.00	0.10	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		1.00	0.00	1.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	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	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	1,394	166	42	1	1,603	21.00
22.00	Skilled Nursing Visit Charges	223,040	26,560	6,720	160	256,480	22.00
23.00	Physical Therapy Visits	974	131	8	4	1,117	23.00
24.00	Physical Therapy Visit Charges	199,670	26,855	1,640	820	228,985	24.00
25.00	Occupational Therapy Visits	268	105	1	2	376	25.00
26.00	Occupational Therapy Visit Charges	54,985	21,525	205	410	77,125	26.00
27.00	Speech Pathology Visits	90	56	0	4	150	27.00
28.00	Speech Pathology Visit Charges	18,450	11,480	0	820	30,750	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	192	35	0	3	230	31.00
32.00	Home Health Aide Visit Charges	14,400	2,625	0	225	17,250	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,918	493	51	14	3,476	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)	510,545	89,045	8,565	2,435	610,590	35.00
36.00	Total Number of Episodes (standard/non outlier)	243		25	0	268	36.00
37.00	Total Number of Outlier Episodes		22		1	23	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8 | Date/Time Prepared: 4/28/2021 8:15 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			7851 S. PROFESSIONAL DR.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FORT BRANCH		IN	47648	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		GIBSON				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: 15-1319 Component CCN: 15-8524	Period: From 10/01/2019 To 09/30/2020	Worksheet S-8 Date/Time Prepared: 4/28/2021 8:15 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	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-8 | Date/Time Prepared: 4/28/2021 8:15 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			510 N MAIN ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PRINCETON		IN	47670	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		GIBSON				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: 15-1319
Component CCN: 15-8553

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

Worksheet S-8

Date/Time Prepared:
4/28/2021 8:15 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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-10 | Date/Time Prepared: 4/28/2021 8:15 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)	0.532386	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,630,335	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,101,401	6.00
7.00	Medicaid cost (line 1 times line 6)	4,313,072	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,682,737	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,682,737	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)	215,842	0	215,842	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	114,911	0	114,911	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)	114,911	0	114,911	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,665,099	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	186,330	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	286,661	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,378,438	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,366,578	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,481,489	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,164,226	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,336,832	2,336,832	231,651	2,568,483	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	85,318	1,504,458	1,589,776	-668,392	921,384	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,541,521	5,745,586	7,287,107	-785,094	6,502,013	5.00
7.00	00700	OPERATION OF PLANT	180,864	790,642	971,506	1,656,128	2,627,634	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,367	30,177	75,544	5,651	81,195	8.00
9.00	00900	HOUSEKEEPING	262,579	125,088	387,667	25,991	413,658	9.00
10.00	01000	DIETARY	347,253	323,199	670,452	-484,403	186,049	10.00
11.00	01100	CAFETERIA	0	0	0	527,961	527,961	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,362	6,362	-1,708	4,654	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	182,914	87,533	270,447	17,953	288,400	14.00
15.00	01500	PHARMACY	146,600	593,667	740,267	820	741,087	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	237,784	76,334	314,118	13,804	327,922	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,631,672	958,253	2,589,925	12,635	2,602,560	30.00
31.00	03100	INTENSIVE CARE UNIT	0	712	712	-87	625	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,059,352	730,705	1,790,057	-246,499	1,543,558	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	683,689	708,943	1,392,632	-289,327	1,103,305	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	164,703	164,703	-24,477	140,226	54.03
60.00	06000	LABORATORY	680,119	1,694,884	2,375,003	8,605	2,383,608	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	59,616	59,616	0	59,616	62.00
65.00	06500	RESPIRATORY THERAPY	385,539	494,228	879,767	448	880,215	65.00
66.00	06600	PHYSICAL THERAPY	602,110	271,343	873,453	23,057	896,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,318	45,658	242,976	4,857	247,833	67.00
68.00	06800	SPEECH PATHOLOGY	77,535	17,845	95,380	1,577	96,957	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	371	371	269,079	269,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	423,720	423,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,829,952	1,829,952	0	1,829,952	73.00
76.00	03480	INFUSION THERAPY	90,896	56,819	147,715	1,066	148,781	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	206,538	142,588	349,126	-13,779	335,347	88.00
88.01	08801	CLARK & WELLS RHC	621,830	280,176	902,006	-643,365	258,641	88.01
90.00	09000	CLINIC	8,019	4,486	12,505	409	12,914	90.00
90.01	09001	DIABETES	0	1,057	1,057	-871	186	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	151,263	391,093	542,356	-183,155	359,201	90.03
91.00	09100	EMERGENCY	902,611	1,573,812	2,476,423	20,827	2,497,250	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	459,861	218,858	678,719	29,437	708,156	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		231,938	231,938	-231,938	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,788,552	21,497,918	32,286,470	-297,419	31,989,051	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	2,334,482	1,543,271	3,877,753	297,572	4,175,325	194.00
194.01	07951	FOUNDATION	46,825	7,351	54,176	-153	54,023	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	-19,818	-19,818	0	-19,818	194.03
194.04	07954	TELE BEHAVIORAL	4,666	42,856	47,522	0	47,522	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	13,174,525	23,071,578	36,246,103	0	36,246,103	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-52,326	2,516,157		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,360,566	2,281,950		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,344,202	8,846,215		5.00
7.00	00700	OPERATION OF PLANT	-249,103	2,378,531		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	81,195		8.00
9.00	00900	HOUSEKEEPING	210,589	624,247		9.00
10.00	01000	DIETARY	80,720	266,769		10.00
11.00	01100	CAFETERIA	-112,360	415,601		11.00
13.00	01300	NURSING ADMINISTRATION	295,404	300,058		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	288,400		14.00
15.00	01500	PHARMACY	330,999	1,072,086		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,605	369,527		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-346,832	2,255,728		30.00
31.00	03100	INTENSIVE CARE UNIT	0	625		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-767,429	776,129		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,103,305		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	140,226		54.03
60.00	06000	LABORATORY	0	2,383,608		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	59,616		62.00
65.00	06500	RESPIRATORY THERAPY	-60,659	819,556		65.00
66.00	06600	PHYSICAL THERAPY	0	896,510		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	247,833		67.00
68.00	06800	SPEECH PATHOLOGY	0	96,957		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	269,450		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	423,720		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-59,522	1,770,430		73.00
76.00	03480	INFUSION THERAPY	-25,000	123,781		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FORT BRANCH RHC	0	335,347		88.00
88.01	08801	CLARK & WELLS RHC	0	258,641		88.01
90.00	09000	CLINIC	0	12,914		90.00
90.01	09001	DIABETES	0	186		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	359,201		90.03
91.00	09100	EMERGENCY	0	2,497,250		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	708,156		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,990,854	34,979,905		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	4,175,325		194.00
194.01	07951	FOUNDATION	0	54,023		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	-19,818		194.03
194.04	07954	TELE BEHAVIORAL	0	47,522		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	2,990,854	39,236,957		200.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	274,816	253,145	1.00
	0		274,816	253,145	
	B - MED SUPPLY CHG PTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	269,079	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	423,720	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	692,799	
	C - BUSINESS HEALTH SER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	54,546	17,830	1.00
	0		54,546	17,830	
	D - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	231,651	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	287	2.00
	0		0	231,938	
	E - QUALITY SERVICES				
1.00	ADMINISTRATIVE & GENERAL	5.00	67,430	26,708	1.00
	0		67,430	26,708	
	F - HEALTH INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	104,673	1.00
2.00	OPERATION OF PLANT	7.00	0	10,311	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	7,534	3.00
4.00	HOUSEKEEPING	9.00	0	26,609	4.00
5.00	DIETARY	10.00	0	46,887	5.00
6.00	CENTRAL SERVICE & SUPPLY	14.00	0	18,123	6.00
7.00	PHARMACY	15.00	0	7,459	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	13,804	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	110,128	9.00
10.00	OPERATING ROOM	50.00	0	48,606	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,011	11.00
12.00	LABORATORY	60.00	0	21,443	12.00
13.00	RESPIRATORY THERAPY	65.00	0	22,988	13.00
14.00	PHYSICAL THERAPY	66.00	0	39,209	14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	6,524	15.00
16.00	SPEECH PATHOLOGY	68.00	0	1,577	16.00
17.00	INFUSION THERAPY	76.00	0	3,466	17.00
18.00	FORT BRANCH RHC	88.00	0	11,074	18.00
19.00	CLINIC	90.00	0	438	19.00
20.00	PAIN MANAGEMENT	90.03	0	7,460	20.00
21.00	EMERGENCY	91.00	0	27,605	21.00
22.00	HOME HEALTH AGENCY	101.00	0	29,744	22.00
23.00	MOB	194.00	0	143,994	23.00
24.00	CLARK & WELLS RHC	88.01	0	9,624	24.00
	0		0	741,291	
	G - WELLNESS CENTER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	523	1.00
	0		0	523	
	I - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	69,473	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	69,473	
	J - MOB COLLECTION EXPENSE				
1.00	OPERATING ROOM	50.00	0	636	1.00
2.00	FORT BRANCH RHC	88.00	0	36	2.00
3.00	MOB	194.00	0	1,610	3.00
	0		0	2,282	

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	190,952	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	190,952	
	L - HRS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	24,719	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	24,719	
	M - RHC RECLASS				
1.00	MOB	194.00	440,462	133,604	1.00
	TOTALS		440,462	133,604	
	N - MAINTENANCE RECLASS				
1.00	OPERATION OF PLANT	7.00	0	1,454,865	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	TOTALS		0	1,454,865	
	O - FORT BRANCH PHYS RECLASS				
1.00	FORT BRANCH RHC	88.00	0	18,304	1.00
	TOTALS		0	18,304	
	P - FORT BRANCH SIMPSON RECLASS				
1.00	CLARK & WELLS RHC	88.01	18,224	0	1.00
	TOTALS		18,224	0	
500.00	Grand Total: Increases		855,478	3,858,433	500.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-6 | Date/Time Prepared: 4/28/2021 8:15 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	274,816	253,145	0		1.00
	0		274,816	253,145			
	B - MED SUPPLY CHG PTS						
1.00	PHARMACY	15.00	0	2	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,943	0		2.00
3.00	OPERATING ROOM	50.00	0	161,351	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,112	0		4.00
5.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.03	0	24,477	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	11,649	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	2,192	0		7.00
8.00	INFUSION THERAPY	76.00	0	2,313	0		8.00
9.00	FORT BRANCH RHC	88.00	0	22,845	0		9.00
10.00	CLINIC	90.00	0	29	0		10.00
11.00	PAIN MANAGEMENT	90.03	0	187,801	0		11.00
12.00	EMERGENCY	91.00	0	5,054	0		12.00
13.00	HOME HEALTH AGENCY	101.00	0	205	0		13.00
14.00	MOB	194.00	0	202,604	0		14.00
15.00	CLARK & WELLS RHC	88.01	0	67,222	0		15.00
	0		0	692,799			
	C - BUSINESS HEALTH SER						
1.00	MOB	194.00	54,546	17,830	0		1.00
	0		54,546	17,830			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	231,938	10		1.00
2.00		0.00	0	0	0		2.00
	0		0	231,938			
	E - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	67,430	26,708	0		1.00
	0		67,430	26,708			
	F - HEALTH INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	741,291	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
	0		0	741,291			
	G - WELLNESS CENTER						
1.00	MOB	194.00	0	523	0		1.00
	0		0	523			
	I - MALPRACTICE						
1.00	OPERATING ROOM	50.00	0	19,968	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	614	0		2.00
3.00	FORT BRANCH RHC	88.00	0	1,224	0		3.00
4.00	PAIN MANAGEMENT	90.03	0	184	0		4.00
5.00	MOB	194.00	0	36,967	0		5.00
6.00	CLARK & WELLS RHC	88.01	0	10,516	0		6.00
	0		0	69,473			
	J - MOB COLLECTION EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,953	0		1.00
2.00	CLARK & WELLS RHC	88.01	0	329	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	2,282			

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-6 | Date/Time Prepared: 4/28/2021 8:15 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - UTILITIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,428	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,708	0		2.00
3.00	OPERATING ROOM	50.00	0	60,395	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	9,742	0		4.00
5.00	DIABETES	90.01	0	871	0		5.00
6.00	HOME HEALTH AGENCY	101.00	0	102	0		6.00
7.00	MOB	194.00	0	56,445	0		7.00
8.00	CLARK & WELLS RHC	88.01	0	11,261	0		8.00
	0		0	190,952			
	L - HRS RECLASS						
1.00	OPERATING ROOM	50.00	0	1,725	0		1.00
2.00	FORT BRANCH RHC	88.00	0	900	0		2.00
3.00	CLARK & WELLS RHC	88.01	0	5,590	0		3.00
4.00	PAIN MANAGEMENT	90.03	0	5	0		4.00
5.00	MOB	194.00	0	16,499	0		5.00
	0		0	24,719			
	M - RHC RECLASS						
1.00	CLARK & WELLS RHC	88.01	440,462	133,604	0		1.00
	TOTALS		440,462	133,604			
	N - MAINTENANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00		1,026,003	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00		1,883	0		2.00
3.00	HOUSEKEEPING	9.00		618	0		3.00
4.00	DIETARY	10.00		3,329	0		4.00
5.00	CENTRAL SERVICE & SUPPLY	14.00		170	0		5.00
6.00	PHARMACY	15.00		6,637	0		6.00
7.00	ADULTS & PEDIATRICS	30.00		412	0		7.00
8.00	INTENSIVE CARE UNIT	31.00		87	0		8.00
9.00	OPERATING ROOM	50.00		52,302	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00		309,226	0		10.00
11.00	LABORATORY	60.00		12,838	0		11.00
12.00	RESPIRATORY THERAPY	65.00		10,277	0		12.00
13.00	PHYSICAL THERAPY	66.00		4,218	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00		1,667	0		14.00
15.00	INFUSION THERAPY	76.00		87	0		15.00
16.00	CLARK & WELLS RHC	88.01		2,229	0		16.00
17.00	PAIN MANAGEMENT	90.03		2,625	0		17.00
18.00	EMERGENCY	91.00		1,724	0		18.00
19.00	MOB	194.00		18,380	0		19.00
20.00	FOUNDATION	194.01		153	0		20.00
	TOTALS		0	1,454,865			
	O - FORT BRANCH PHYS RECLASS						
1.00	MOB	194.00	0	18,304	0		1.00
	TOTALS		0	18,304			
	P - FORT BRANCH SIMPSON RECLASS						
1.00	FORT BRANCH RHC	88.00	18,224	0	0		1.00
	TOTALS		18,224	0			
500.00	Grand Total: Decreases		855,478	3,858,433			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part I | Date/Time Prepared: 4/28/2021 8:15 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	680,034	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,707,979	788,127	0	788,127	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	17,360,975	4,990,072	0	4,990,072	120,986	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,748,988	5,778,199	0	5,778,199	120,986	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,748,988	5,778,199	0	5,778,199	120,986	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	680,034	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	20,496,106	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	22,230,061	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,406,201	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	43,406,201	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part II | Date/Time Prepared: 4/28/2021 8:15 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,068,894	0	0	259,062	8,876	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,068,894	0	0	259,062	8,876	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,336,832		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,336,832		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part III | Date/Time Prepared: 4/28/2021 8:15 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	CAP REL COSTS-BLDG & FIXT	43,406,201	0	43,406,201	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	43,406,201	0	43,406,201	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,068,894	179,325	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,068,894	179,325	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	259,062	8,876	0	2,516,157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	259,062	8,876	0	2,516,157	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8 | Date/Time Prepared: 4/28/2021 8:15 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-52,326	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	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)	A	-277	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,107	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-117	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-899,040			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	5,876,174			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-112,360	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,123	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8 | Date/Time Prepared: 4/28/2021 8:15 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	MISC INCOME	B	-9,512	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC INCOME	B	-14,021	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN RECRUITING	A	-8,597	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	ADVERTISING	A	-123,799	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HAF FEE	A	-1,294,759	ADMINISTRATIVE & GENERAL	5.00	0	33.04
34.00	LOBBYING	A	-880	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	340B	A	-59,522	DRUGS CHARGED TO PATIENTS	73.00	0	34.01
35.00	CRNA	A	-300,880	OPERATING ROOM	50.00	0	35.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,990,854				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 4/28/2021 8:15 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,369,163	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,320,228	0	2.00
3.00	7.00	OPERATION OF PLANT	HOME OFFICE	474,267	717,146	3.00
3.01	9.00	HOUSEKEEPING	HOME OFFICE	210,589	0	3.01
3.02	10.00	DIETARY	HOME OFFICE	80,720	0	3.02
4.00	13.00	NURSING ADMINISTRATION	HOME OFFICE	86,809	0	4.00
4.01	15.00	PHARMACY	HOME OFFICE	330,999	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	44,728	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	194,460	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,172,833	88,497	4.04
4.05	13.00	NURSING ADMINISTRATION	HOME OFFICE	208,595	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	657,907	469,481	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,151,298	1,275,124	5.00

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

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

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

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

6.00	G		0.00	DEACONESS HOSP	100.00	6.00
7.00	G		0.00	HRS	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1319	Period: From 10/01/2019 To 09/30/2020	Worksheet A-8-1 Date/Time Prepared: 4/28/2021 8:15 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,369,163	0		1.00
2.00	2,320,228	0		2.00
3.00	-242,879	0		3.00
3.01	210,589	0		3.01
3.02	80,720	0		3.02
4.00	86,809	0		4.00
4.01	330,999	0		4.01
4.02	44,728	0		4.02
4.03	194,460	0		4.03
4.04	1,084,336	0		4.04
4.05	208,595	0		4.05
4.06	188,426	0		4.06
5.00	5,876,174			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	PFS		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 4/28/2021 8:15 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	346,832	346,832	0	0	0	1.00
2.00	50.00	OPERATING ROOM	466,549	466,549	0	0	0	2.00
3.00	60.00	LABORATORY	40,000	0	40,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	60,659	60,659	0	0	0	4.00
5.00	76.00	INFUSION THERAPY	25,000	25,000	0	0	0	5.00
6.00	91.00	EMERGENCY	1,258,137	0	1,258,137	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,197,177	899,040	1,298,137		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	76.00	INFUSION THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	346,832		1.00
2.00	50.00	OPERATING ROOM	0	0	0	466,549		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	60,659		4.00
5.00	76.00	INFUSION THERAPY	0	0	0	25,000		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	899,040		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,516,157	2,516,157				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,281,950	19,212	0	2,301,162		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,846,215	136,868	0	284,047	9,267,130	5.00
7.00	00700	OPERATION OF PLANT	2,378,531	686,476	0	31,930	3,096,937	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,195	44,672	0	8,009	133,876	8.00
9.00	00900	HOUSEKEEPING	624,247	25,214	0	46,356	695,817	9.00
10.00	01000	DIETARY	266,769	90,770	0	12,788	370,327	10.00
11.00	01100	CAFETERIA	415,601	23,926	0	48,517	488,044	11.00
13.00	01300	NURSING ADMINISTRATION	300,058	7,564	0	0	307,622	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	288,400	0	0	32,292	320,692	14.00
15.00	01500	PHARMACY	1,072,086	0	0	25,881	1,097,967	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	369,527	36,533	0	41,979	448,039	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,255,728	251,153	0	276,154	2,783,035	30.00
31.00	03100	INTENSIVE CARE UNIT	625	53,059	0	0	53,684	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	776,129	139,882	0	187,020	1,103,031	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,103,305	95,813	0	120,700	1,319,818	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	140,226	11,511	0	0	151,737	54.03
60.00	06000	LABORATORY	2,383,608	41,932	0	120,070	2,545,610	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	59,616	0	0	0	59,616	62.00
65.00	06500	RESPIRATORY THERAPY	819,556	44,179	0	68,064	931,799	65.00
66.00	06600	PHYSICAL THERAPY	896,510	77,039	0	106,298	1,079,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,833	22,418	0	34,835	305,086	67.00
68.00	06800	SPEECH PATHOLOGY	96,957	1,699	0	13,688	112,344	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	269,450	98,362	0	0	367,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	423,720	0	0	0	423,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,770,430	36,779	0	0	1,807,209	73.00
76.00	03480	INFUSION THERAPY	123,781	29,243	0	16,047	169,071	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	335,347	0	0	33,245	368,592	88.00
88.01	08801	CLARK & WELLS RHC	258,641	11,511	0	35,236	305,388	88.01
90.00	09000	CLINIC	12,914	0	0	1,416	14,330	90.00
90.01	09001	DIABETES	186	0	0	0	186	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	359,201	43,165	0	26,704	429,070	90.03
91.00	09100	EMERGENCY	2,497,250	213,277	0	159,349	2,869,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	708,156	13,840	0	81,185	803,181	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,979,905	2,256,097	0	1,811,810	34,230,493	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	4,175,325	224,185	0	480,261	4,879,771	194.00
194.01	07951	FOUNDATION	54,023	35,875	0	8,267	98,165	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	-19,818	0	0	0	-19,818	194.03
194.04	07954	TELE BEHAVIORAL	47,522	0	0	824	48,346	194.04
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)	39,236,957	2,516,157	0	2,301,162	39,236,957	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,267,130					5.00
7.00	00700	OPERATION OF PLANT	956,988	4,053,925				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,369	108,209	283,454			8.00
9.00	00900	HOUSEKEEPING	215,015	61,075	0	971,907		9.00
10.00	01000	DIETARY	114,435	219,870	0	55,010	759,642	10.00
11.00	01100	CAFETERIA	150,811	57,955	0	14,500	0	11.00
13.00	01300	NURSING ADMINISTRATION	95,059	18,323	0	4,584	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	99,097	0	0	0	0	14.00
15.00	01500	PHARMACY	339,284	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138,449	88,492	0	22,140	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	859,988	608,361	271,726	152,204	728,211	30.00
31.00	03100	INTENSIVE CARE UNIT	16,589	128,523	11,728	32,156	31,431	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	340,849	338,834	0	84,774	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	407,838	232,085	0	58,066	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	46,888	27,882	0	6,976	0	54.03
60.00	06000	LABORATORY	786,621	101,571	0	25,412	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	18,422	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	287,936	107,014	0	26,774	0	65.00
66.00	06600	PHYSICAL THERAPY	333,685	186,611	0	46,689	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,275	54,304	0	13,586	0	67.00
68.00	06800	SPEECH PATHOLOGY	34,716	4,116	0	1,030	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,658	238,259	0	59,611	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	130,934	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	558,447	89,090	0	22,290	0	73.00
76.00	03480	INFUSION THERAPY	52,245	70,834	0	17,722	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	113,899	0	0	0	0	88.00
88.01	08801	CLARK & WELLS RHC	94,368	27,882	0	6,976	0	88.01
90.00	09000	CLINIC	4,428	0	0	0	0	90.00
90.01	09001	DIABETES	57	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	132,587	104,558	0	26,160	0	90.03
91.00	09100	EMERGENCY	886,823	516,616	0	129,253	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	248,192	33,525	0	8,388	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,713,952	3,423,989	283,454	814,301	759,642	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,507,905	543,037	0	135,864	0	194.00
194.01	07951	FOUNDATION	30,334	86,899	0	21,742	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	14,939	0	0	0	0	194.04
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)	9,267,130	4,053,925	283,454	971,907	759,642	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	711,310					11.00
13.00	01300	NURSING ADMINISTRATION	0	425,588				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	12,308	0	432,097			14.00
15.00	01500	PHARMACY	9,864	0	2,908	1,450,023		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,000	0	22	0	713,142	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,252	166,200	11,933	0	30,970	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	19	0	963	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,280	32,192	35,931	0	73,036	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,003	0	9,014	0	125,796	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	8,549	0	5,648	54.03
60.00	06000	LABORATORY	45,762	15	118,995	0	89,044	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	13,964	0	1,787	62.00
65.00	06500	RESPIRATORY THERAPY	25,941	8,979	3,584	0	33,349	65.00
66.00	06600	PHYSICAL THERAPY	40,514	0	7,230	0	50,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,277	0	633	0	18,269	67.00
68.00	06800	SPEECH PATHOLOGY	5,217	0	90	0	5,760	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	64,401	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	101,413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,528	0	1,450,023	90,090	73.00
76.00	03480	INFUSION THERAPY	6,116	14,413	2,857	0	5,567	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	12,671	0	1,120	0	4,216	88.00
88.01	08801	CLARK & WELLS RHC	13,430	0	1,006	0	4,644	88.01
90.00	09000	CLINIC	540	1,212	363	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	52	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	10,178	6,772	12,310	0	15,501	90.03
91.00	09100	EMERGENCY	60,733	140,631	17,311	0	73,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	30,942	42,646	3,283	0	8,926	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	526,028	425,588	416,936	1,450,023	636,823	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	181,817	0	15,161	0	76,240	194.00
194.01	07951	FOUNDATION	3,151	0	0	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	314	0	0	0	79	194.04
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)	711,310	425,588	432,097	1,450,023	713,142	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,717,880	0	5,717,880		30.00
31.00	03100	INTENSIVE CARE UNIT	275,093	0	275,093		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,079,927	0	2,079,927		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,198,620	0	2,198,620		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	247,680	0	247,680		54.03
60.00	06000	LABORATORY	3,713,030	0	3,713,030		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	93,789	0	93,789		62.00
65.00	06500	RESPIRATORY THERAPY	1,425,376	0	1,425,376		65.00
66.00	06600	PHYSICAL THERAPY	1,744,768	0	1,744,768		66.00
67.00	06700	OCCUPATIONAL THERAPY	499,430	0	499,430		67.00
68.00	06800	SPEECH PATHOLOGY	163,273	0	163,273		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	843,741	0	843,741		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	656,067	0	656,067		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,029,677	0	4,029,677		73.00
76.00	03480	INFUSION THERAPY	338,825	0	338,825		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FORT BRANCH RHC	500,498	0	500,498		88.00
88.01	08801	CLARK & WELLS RHC	453,694	0	453,694		88.01
90.00	09000	CLINIC	20,873	0	20,873		90.00
90.01	09001	DIABETES	295	0	295		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	737,136	0	737,136		90.03
91.00	09100	EMERGENCY	4,694,256	0	4,694,256		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,179,083	0	1,179,083		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,613,011	0	31,613,011		118.00
		NONREIMBURSABLE COST CENTERS					
194.00	07950	MOB	7,339,795	0	7,339,795		194.00
194.01	07951	FOUNDATION	240,291	0	240,291		194.01
194.02	07952	ASC	0	0	0		194.02
194.03	07953	SNF - PERRY CO.	-19,818	0	-19,818		194.03
194.04	07954	TELE BEHAVIORAL	63,678	0	63,678		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	39,236,957	0	39,236,957		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,212	0	19,212	19,212	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	136,868	0	136,868	2,372	5.00
7.00	00700	OPERATION OF PLANT	0	686,476	0	686,476	267	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,672	0	44,672	67	8.00
9.00	00900	HOUSEKEEPING	0	25,214	0	25,214	387	9.00
10.00	01000	DIETARY	0	90,770	0	90,770	107	10.00
11.00	01100	CAFETERIA	0	23,926	0	23,926	405	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,564	0	7,564	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	270	14.00
15.00	01500	PHARMACY	0	0	0	0	216	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,533	0	36,533	350	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	251,153	0	251,153	2,306	30.00
31.00	03100	INTENSIVE CARE UNIT	0	53,059	0	53,059	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	139,882	0	139,882	1,561	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	95,813	0	95,813	1,008	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	11,511	0	11,511	0	54.03
60.00	06000	LABORATORY	0	41,932	0	41,932	1,002	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	44,179	0	44,179	568	65.00
66.00	06600	PHYSICAL THERAPY	0	77,039	0	77,039	888	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	22,418	0	22,418	291	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,699	0	1,699	114	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	98,362	0	98,362	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	36,779	0	36,779	0	73.00
76.00	03480	INFUSION THERAPY	0	29,243	0	29,243	134	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0	0	0	0	278	88.00
88.01	08801	CLARK & WELLS RHC	0	11,511	0	11,511	294	88.01
90.00	09000	CLINIC	0	0	0	0	12	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	43,165	0	43,165	223	90.03
91.00	09100	EMERGENCY	0	213,277	0	213,277	1,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	13,840	0	13,840	678	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,256,097	0	2,256,097	15,128	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	224,185	0	224,185	4,008	194.00
194.01	07951	FOUNDATION	0	35,875	0	35,875	69	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	7	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,516,157	0	2,516,157	19,212	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	139,240					5.00
7.00	00700	OPERATION OF PLANT	14,379	701,122				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	622	18,715	64,076			8.00
9.00	00900	HOUSEKEEPING	3,231	10,563	0	39,395		9.00
10.00	01000	DIETARY	1,719	38,026	0	2,230	132,852	10.00
11.00	01100	CAFETERIA	2,266	10,023	0	588	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,428	3,169	0	186	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,489	0	0	0	0	14.00
15.00	01500	PHARMACY	5,098	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,080	15,305	0	897	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,922	105,214	61,425	6,171	127,355	30.00
31.00	03100	INTENSIVE CARE UNIT	249	22,228	2,651	1,303	5,497	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,121	58,601	0	3,436	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,128	40,139	0	2,354	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	705	4,822	0	283	0	54.03
60.00	06000	LABORATORY	11,819	17,567	0	1,030	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	277	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	4,326	18,508	0	1,085	0	65.00
66.00	06600	PHYSICAL THERAPY	5,014	32,274	0	1,892	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,417	9,392	0	551	0	67.00
68.00	06800	SPEECH PATHOLOGY	522	712	0	42	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,708	41,207	0	2,416	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,967	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,391	15,408	0	903	0	73.00
76.00	03480	INFUSION THERAPY	785	12,251	0	718	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	1,711	0	0	0	0	88.00
88.01	08801	CLARK & WELLS RHC	1,418	4,822	0	283	0	88.01
90.00	09000	CLINIC	67	0	0	0	0	90.00
90.01	09001	DIABETES	1	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,992	18,083	0	1,060	0	90.03
91.00	09100	EMERGENCY	13,325	89,348	0	5,239	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,729	5,798	0	340	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,906	592,175	64,076	33,007	132,852	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	22,654	93,918	0	5,507	0	194.00
194.01	07951	FOUNDATION	456	15,029	0	881	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	224	0	0	0	0	194.04
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)	139,240	701,122	64,076	39,395	132,852	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	37,208					11.00
13.00	01300	NURSING ADMINISTRATION	0	12,347				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	644	0	2,403			14.00
15.00	01500	PHARMACY	516	0	16	5,846		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	837	0	0	0	56,002	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,506	4,824	66	0	2,432	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	76	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,729	934	200	0	5,736	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,407	0	50	0	9,873	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	48	0	444	54.03
60.00	06000	LABORATORY	2,394	0	662	0	6,994	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	78	0	140	62.00
65.00	06500	RESPIRATORY THERAPY	1,357	260	20	0	2,619	65.00
66.00	06600	PHYSICAL THERAPY	2,119	0	40	0	3,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	695	0	4	0	1,435	67.00
68.00	06800	SPEECH PATHOLOGY	273	0	1	0	452	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	358	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	564	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	363	0	5,846	7,076	73.00
76.00	03480	INFUSION THERAPY	320	418	16	0	437	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	663	0	6	0	331	88.00
88.01	08801	CLARK & WELLS RHC	703	0	6	0	365	88.01
90.00	09000	CLINIC	28	35	2	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	4	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	532	196	68	0	1,217	90.03
91.00	09100	EMERGENCY	3,177	4,080	96	0	5,734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,619	1,237	18	0	701	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,519	12,347	2,319	5,846	50,008	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	9,508	0	84	0	5,988	194.00
194.01	07951	FOUNDATION	165	0	0	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	16	0	0	0	6	194.04
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)	37,208	12,347	2,403	5,846	56,002	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	579,374	0	579,374		30.00
31.00	03100	INTENSIVE CARE UNIT	85,063	0	85,063		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	219,200	0	219,200		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,772	0	157,772		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	17,813	0	17,813		54.03
60.00	06000	LABORATORY	83,400	0	83,400		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	495	0	495		62.00
65.00	06500	RESPIRATORY THERAPY	72,922	0	72,922		65.00
66.00	06600	PHYSICAL THERAPY	123,208	0	123,208		66.00
67.00	06700	OCCUPATIONAL THERAPY	36,203	0	36,203		67.00
68.00	06800	SPEECH PATHOLOGY	3,815	0	3,815		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	144,051	0	144,051		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,531	0	2,531		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,766	0	74,766		73.00
76.00	03480	INFUSION THERAPY	44,322	0	44,322		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	FORT BRANCH RHC	2,989	0	2,989		88.00
88.01	08801	CLARK & WELLS RHC	19,402	0	19,402		88.01
90.00	09000	CLINIC	144	0	144		90.00
90.01	09001	DIABETES	5	0	5		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	66,536	0	66,536		90.03
91.00	09100	EMERGENCY	335,606	0	335,606		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	27,960	0	27,960		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,097,577	0	2,097,577		118.00
		NONREIMBURSABLE COST CENTERS					
194.00	07950	MOB	365,852	0	365,852		194.00
194.01	07951	FOUNDATION	52,475	0	52,475		194.01
194.02	07952	ASC	0	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0	0		194.03
194.04	07954	TELE BEHAVIORAL	253	0	253		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,516,157	0	2,516,157		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	91,809					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		91,809				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	701	701	13,034,661			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,994	4,994	1,608,951	-9,267,130	29,989,645	5.00
7.00	00700	OPERATION OF PLANT	25,048	25,048	180,864	0	3,096,937	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	45,367	0	133,876	8.00
9.00	00900	HOUSEKEEPING	920	920	262,579	0	695,817	9.00
10.00	01000	DIETARY	3,312	3,312	72,437	0	370,327	10.00
11.00	01100	CAFETERIA	873	873	274,816	0	488,044	11.00
13.00	01300	NURSING ADMINISTRATION	276	276	0	0	307,622	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	182,914	0	320,692	14.00
15.00	01500	PHARMACY	0	0	146,600	0	1,097,967	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	1,333	237,784	0	448,039	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,164	9,164	1,564,242	0	2,783,035	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	1,936	0	0	53,684	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	5,104	1,059,352	0	1,103,031	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	3,496	683,689	0	1,319,818	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	151,737	54.03
60.00	06000	LABORATORY	1,530	1,530	680,119	0	2,545,610	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	59,616	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	1,612	385,539	0	931,799	65.00
66.00	06600	PHYSICAL THERAPY	2,811	2,811	602,110	0	1,079,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	818	197,318	0	305,086	67.00
68.00	06800	SPEECH PATHOLOGY	62	62	77,535	0	112,344	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,589	3,589	0	0	367,812	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	423,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,342	1,342	0	0	1,807,209	73.00
76.00	03480	INFUSION THERAPY	1,067	1,067	90,896	0	169,071	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0	0	188,314	0	368,592	88.00
88.01	08801	CLARK & WELLS RHC	420	420	199,592	0	305,388	88.01
90.00	09000	CLINIC	0	0	8,019	0	14,330	90.00
90.01	09001	DIABETES	0	0	0	0	186	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,575	1,575	151,263	0	429,070	90.03
91.00	09100	EMERGENCY	7,782	7,782	902,611	0	2,869,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	505	459,861	0	803,181	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,320	82,320	10,262,772	-9,267,130	24,963,363	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,180	8,180	2,720,398	0	4,879,771	194.00
194.01	07951	FOUNDATION	1,309	1,309	46,825	0	98,165	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	19,818	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	4,666	0	48,346	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,516,157	0	2,301,162		9,267,130	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.406431	0.000000	0.176542		0.309011	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			19,212		139,240	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001474		0.004643	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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	61,066					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,861				8.00
9.00	00900	HOUSEKEEPING	920	0	58,516			9.00
10.00	01000	DIETARY	3,312	0	3,312	1,861		10.00
11.00	01100	CAFETERIA	873	0	873	0	10,571,423	11.00
13.00	01300	NURSING ADMINISTRATION	276	0	276	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	182,914	14.00
15.00	01500	PHARMACY	0	0	0	0	146,600	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	0	1,333	0	237,784	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,164	1,784	9,164	1,784	1,564,242	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	77	1,936	77	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	0	5,104	0	1,059,352	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	0	3,496	0	683,689	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	0	54.03
60.00	06000	LABORATORY	1,530	0	1,530	0	680,119	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	0	1,612	0	385,539	65.00
66.00	06600	PHYSICAL THERAPY	2,811	0	2,811	0	602,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	197,318	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	62	0	77,535	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,589	0	3,589	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	1,342	0	1,342	0	0	73.00
76.00	03480	INFUSION THERAPY	1,067	0	1,067	0	90,896	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0	0	0	0	188,314	88.00
88.01	08801	CLARK & WELLS RHC	420	0	420	0	199,591	88.01
90.00	09000	CLINIC	0	0	0	0	8,019	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,575	0	1,575	0	151,263	90.03
91.00	09100	EMERGENCY	7,782	0	7,782	0	902,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	0	505	0	459,861	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,577	1,861	49,027	1,861	7,817,757	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,180	0	8,180	0	2,702,175	194.00
194.01	07951	FOUNDATION	1,309	0	1,309	0	46,825	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	4,666	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,053,925	283,454	971,907	759,642	711,310	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	66.385959	152.312735	16.609252	408.190220	0.067286	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	701,122	64,076	39,395	132,852	37,208	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.481381	34.430951	0.673235	71.387426	0.003520	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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 4/28/2021 8:15 am

		Cost Center Description	NURSING ADMINISTRATION (NURSE SALARIES)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,671,125					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	1,805,368				14.00
15.00	01500	PHARMACY	0	12,149	1,828,057			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	90	0	67,240,256		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,043,112	49,856	0	2,920,051		30.00
31.00	03100	INTENSIVE CARE UNIT	0	79	0	90,809		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	202,046	150,124	0	6,886,277		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,661	0	11,861,557		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	35,721	0	532,563		54.03
60.00	06000	LABORATORY	97	497,179	0	8,395,624		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58,345	0	168,487		62.00
65.00	06500	RESPIRATORY THERAPY	56,357	14,974	0	3,144,388		65.00
66.00	06600	PHYSICAL THERAPY	0	30,210	0	4,732,425		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,646	0	1,722,469		67.00
68.00	06800	SPEECH PATHOLOGY	0	376	0	543,069		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	269,079	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	423,720	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,631	0	1,828,057	8,494,227		73.00
76.00	03480	INFUSION THERAPY	90,463	11,939	0	524,872		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0	4,680	0	397,482		88.00
88.01	08801	CLARK & WELLS RHC	0	4,204	0	437,900		88.01
90.00	09000	CLINIC	7,609	1,517	0	0		90.00
90.01	09001	DIABETES	0	0	0	4,878		90.01
90.02	09002	OP PSYCH	0	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	42,506	51,433	0	1,461,549		90.03
91.00	09100	EMERGENCY	882,645	72,326	0	6,884,130		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	267,659	13,717	0	841,639		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,671,125	1,742,025	1,828,057	60,044,396		118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	63,343	0	7,188,374		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	ASC	0	0	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	7,486		194.04
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)	425,588	432,097	1,450,023	713,142		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.159329	0.239340	0.793204	0.010606		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,347	2,403	5,846	56,002		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004622	0.001331	0.003198	0.000833		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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,717,880		5,717,880	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	275,093		275,093	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,079,927		2,079,927	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,198,620		2,198,620	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	247,680		247,680	0	0	54.03
60.00	06000	LABORATORY	3,713,030		3,713,030	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	93,789		93,789	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,425,376	0	1,425,376	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,744,768	0	1,744,768	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	499,430	0	499,430	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	163,273	0	163,273	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	843,741		843,741	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	656,067		656,067	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,029,677		4,029,677	0	0	73.00
76.00	03480	INFUSION THERAPY	338,825		338,825	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	500,498		500,498	0	0	88.00
88.01	08801	CLARK & WELLS RHC	453,694		453,694	0	0	88.01
90.00	09000	CLINIC	20,873		20,873	0	0	90.00
90.01	09001	DIABETES	295		295	0	0	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	737,136		737,136	0	0	90.03
91.00	09100	EMERGENCY	4,694,256		4,694,256	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,596,670		1,596,670		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,179,083		1,179,083		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,209,681	0	33,209,681	0	0	200.00
201.00		Less Observation Beds	1,596,670		1,596,670		0	201.00
202.00		Total (see instructions)	31,613,011	0	31,613,011	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,049,038		2,049,038			30.00
31.00	03100	INTENSIVE CARE UNIT	86,649		86,649			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	134,252	5,088,371	5,222,623	0.398253	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,873	10,976,388	11,325,261	0.194134	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	2,632	529,010	531,642	0.465877	0.000000	54.03
60.00	06000	LABORATORY	635,368	7,760,256	8,395,624	0.442258	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	64,170	162,343	226,513	0.414056	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	428,770	2,393,993	2,822,763	0.504958	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	739,152	3,991,651	4,730,803	0.368810	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	390,865	1,328,507	1,719,372	0.290472	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	59,053	484,016	543,069	0.300649	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	257,404	684,373	941,777	0.895903	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,724	679,438	684,162	0.958935	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,464,347	7,586,848	9,051,195	0.445209	0.000000	73.00
76.00	03480	INFUSION THERAPY	27,266	722,501	749,767	0.451907	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0	397,482	397,482			88.00
88.01	08801	CLARK & WELLS RHC	0	437,900	437,900			88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	4,878	4,878	0.060476	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	1,187,040	1,187,040	0.620987	0.000000	90.03
91.00	09100	EMERGENCY	220,220	6,330,859	6,551,079	0.716562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	37,087	842,478	879,565	1.815295	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	841,639	841,639			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,949,870	52,429,971	59,379,841			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,949,870	52,429,971	59,379,841			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 4/28/2021 8:15 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	INFUSION THERAPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	FORT BRANCH RHC			88.00
88.01	08801	CLARK & WELLS RHC			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 4/28/2021 8:15 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	5,717,880		5,717,880	0	5,717,880	30.00
31.00	03100	INTENSIVE CARE UNIT	275,093		275,093	0	275,093	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,079,927		2,079,927	0	2,079,927	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,198,620		2,198,620	0	2,198,620	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	247,680		247,680	0	247,680	54.03
60.00	06000	LABORATORY	3,713,030		3,713,030	0	3,713,030	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	93,789		93,789	0	93,789	62.00
65.00	06500	RESPIRATORY THERAPY	1,425,376	0	1,425,376	0	1,425,376	65.00
66.00	06600	PHYSICAL THERAPY	1,744,768	0	1,744,768	0	1,744,768	66.00
67.00	06700	OCCUPATIONAL THERAPY	499,430	0	499,430	0	499,430	67.00
68.00	06800	SPEECH PATHOLOGY	163,273	0	163,273	0	163,273	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	843,741		843,741	0	843,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	656,067		656,067	0	656,067	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,029,677		4,029,677	0	4,029,677	73.00
76.00	03480	INFUSION THERAPY	338,825		338,825	0	338,825	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	500,498		500,498	0	500,498	88.00
88.01	08801	CLARK & WELLS RHC	453,694		453,694	0	453,694	88.01
90.00	09000	CLINIC	20,873		20,873	0	20,873	90.00
90.01	09001	DIABETES	295		295	0	295	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	737,136		737,136	0	737,136	90.03
91.00	09100	EMERGENCY	4,694,256		4,694,256	0	4,694,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,596,670		1,596,670		1,596,670	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,179,083		1,179,083		1,179,083	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,209,681	0	33,209,681	0	33,209,681	200.00
201.00		Less Observation Beds	1,596,670		1,596,670		1,596,670	201.00
202.00		Total (see instructions)	31,613,011	0	31,613,011	0	31,613,011	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I | Date/Time Prepared: 4/28/2021 8:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,049,038		2,049,038			30.00
31.00	03100	INTENSIVE CARE UNIT	86,649		86,649			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	134,252	5,088,371	5,222,623	0.398253	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,873	10,976,388	11,325,261	0.194134	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	2,632	529,010	531,642	0.465877	0.000000	54.03
60.00	06000	LABORATORY	635,368	7,760,256	8,395,624	0.442258	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	64,170	162,343	226,513	0.414056	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	428,770	2,393,993	2,822,763	0.504958	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	739,152	3,991,651	4,730,803	0.368810	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	390,865	1,328,507	1,719,372	0.290472	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	59,053	484,016	543,069	0.300649	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	257,404	684,373	941,777	0.895903	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,724	679,438	684,162	0.958935	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,464,347	7,586,848	9,051,195	0.445209	0.000000	73.00
76.00	03480	INFUSION THERAPY	27,266	722,501	749,767	0.451907	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0	397,482	397,482	1.259171	0.000000	88.00
88.01	08801	CLARK & WELLS RHC	0	437,900	437,900	1.036068	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DIABETES	0	4,878	4,878	0.060476	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	1,187,040	1,187,040	0.620987	0.000000	90.03
91.00	09100	EMERGENCY	220,220	6,330,859	6,551,079	0.716562	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	37,087	842,478	879,565	1.815295	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	841,639	841,639			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,949,870	52,429,971	59,379,841			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,949,870	52,429,971	59,379,841			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 4/28/2021 8:15 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
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	54.03
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03480	INFUSION THERAPY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	FORT BRANCH RHC	0.000000	88.00
88.01	08801	CLARK & WELLS RHC	0.000000	88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	DIABETES	0.000000	90.01
90.02	09002	OP PSYCH	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part II Date/Time Prepared: 4/28/2021 8:15 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	219,200	5,222,623	0.041971	47,301	1,985	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,772	11,325,261	0.013931	95,834	1,335	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	17,813	531,642	0.033506	0	0	54.03
60.00	06000	LABORATORY	83,400	8,395,624	0.009934	177,478	1,763	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	495	226,513	0.002185	26,724	58	62.00
65.00	06500	RESPIRATORY THERAPY	72,922	2,822,763	0.025834	122,976	3,177	65.00
66.00	06600	PHYSICAL THERAPY	123,208	4,730,803	0.026044	51,272	1,335	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,203	1,719,372	0.021056	26,970	568	67.00
68.00	06800	SPEECH PATHOLOGY	3,815	543,069	0.007025	5,707	40	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	144,051	941,777	0.152957	78,498	12,007	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,531	684,162	0.003699	1,727	6	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,766	9,051,195	0.008260	316,807	2,617	73.00
76.00	03480	INFUSION THERAPY	44,322	749,767	0.059114	347	21	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	2,989	397,482	0.007520	0	0	88.00
88.01	08801	CLARK & WELLS RHC	19,402	437,900	0.044307	0	0	88.01
90.00	09000	CLINIC	144	0	0.000000	0	0	90.00
90.01	09001	DIABETES	5	4,878	0.001025	0	0	90.01
90.02	09002	OP PSYCH	0	0	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	66,536	1,187,040	0.056052	0	0	90.03
91.00	09100	EMERGENCY	335,606	6,551,079	0.051229	29,040	1,488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	161,786	879,565	0.183939	5,209	958	92.00
200.00		Total (lines 50 through 199)	1,566,966	56,402,515		985,890	27,358	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0	0	0	0	0	88.00
88.01	08801	CLARK & WELLS RHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/28/2021 8:15 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	5,222,623	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,325,261	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	531,642	0.000000	54.03
60.00	06000	LABORATORY	0	0	0	8,395,624	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	226,513	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,822,763	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,730,803	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,719,372	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	543,069	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	941,777	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	684,162	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,051,195	0.000000	73.00
76.00	03480	INFUSION THERAPY	0	0	0	749,767	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0	0	0	397,482	0.000000	88.00
88.01	08801	CLARK & WELLS RHC	0	0	0	437,900	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	DIABETES	0	0	0	4,878	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	1,187,040	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	6,551,079	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	879,565	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	56,402,515		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 4/28/2021 8:15 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	47,301	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	95,834	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	0	0	0	0	54.03
60.00	06000	LABORATORY	0.000000	177,478	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	26,724	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	122,976	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	51,272	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	26,970	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,707	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	78,498	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,727	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	316,807	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0.000000	347	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC	0.000000	0	0	0	0	88.00
88.01	08801	CLARK & WELLS RHC	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.000000	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	29,040	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,209	0	0	0	92.00
200.00		Total (lines 50 through 199)		985,890	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part V Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.398253	0	1,765,457	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194134	0	2,919,431	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.465877	0	163,917	0	0	54.03
60.00	06000	LABORATORY	0.442258	0	1,816,370	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.414056	0	33,493	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.504958	0	821,515	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.368810	0	1,329,390	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.290472	0	260,247	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.300649	0	59,814	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.895903	0	203,727	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.958935	0	257,960	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.445209	0	3,318,347	881	0	73.00
76.00	03480	INFUSION THERAPY	0.451907	0	261,027	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	FORT BRANCH RHC						88.00
88.01	08801	CLARK & WELLS RHC						88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.060476	0	487	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.620987	0	307,662	0	0	90.03
91.00	09100	EMERGENCY	0.716562	0	1,327,728	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.815295	0	309,828	30	0	92.00
200.00		Subtotal (see instructions)		0	15,156,400	911	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	15,156,400	911	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part V Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	703,099	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	566,761	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	76,365	0		54.03
60.00	06000	LABORATORY	803,304	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	13,868	0		62.00
65.00	06500	RESPIRATORY THERAPY	414,831	0		65.00
66.00	06600	PHYSICAL THERAPY	490,292	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	75,594	0		67.00
68.00	06800	SPEECH PATHOLOGY	17,983	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	182,520	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	247,367	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,477,358	392		73.00
76.00	03480	INFUSION THERAPY	117,960	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FORT BRANCH RHC				88.00
88.01	08801	CLARK & WELLS RHC				88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DIABETES	29	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	191,054	0		90.03
91.00	09100	EMERGENCY	951,399	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	562,429	54		92.00
200.00		Subtotal (see instructions)	6,892,213	446		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,892,213	446		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,115	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,434	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)	729	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)	1,055	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	626	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	373	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)	1,055	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)	5,717,880	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)	80,842	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,470,185	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,247,695	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)	3,247,695	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)	2,264.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	844,763	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)	844,763	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	275,093	77	3,572.64	22	78,598	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)	461,007	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,384,368	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)	2,389,343	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,389,343	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)	705	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,264.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,596,670	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/28/2021 8:15 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	579,374	5,717,880	0.101327	1,596,670	161,786	90.00
91.00	Nursing School cost	0	5,717,880	0.000000	1,596,670	0	91.00
92.00	Allied health cost	0	5,717,880	0.000000	1,596,670	0	92.00
93.00	All other Medical Education	0	5,717,880	0.000000	1,596,670	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/28/2021 8:15 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)	3,115	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,434	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)	729	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	264	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)	791	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	203	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)	423	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	18	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)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,717,880	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)	2,423,609	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,294,271	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)	3,294,271	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)	2,297.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	41,351	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)	41,351	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/28/2021 8:15 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	275,093	77	3,572.64	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)	20,996	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	62,347	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)	705	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,297.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,619,568	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 4/28/2021 8:15 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	579,374	5,717,880	0.101327	1,619,568	164,106	90.00
91.00	Nursing School cost	0	5,717,880	0.000000	1,619,568	0	91.00
92.00	Allied health cost	0	5,717,880	0.000000	1,619,568	0	92.00
93.00	All other Medical Education	0	5,717,880	0.000000	1,619,568	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 4/28/2021 8:15 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		345,997		30.00
31.00	03100	INTENSIVE CARE UNIT		44,872		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.398253	47,301	18,838	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194134	95,834	18,605	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.465877	0	0	54.03
60.00	06000	LABORATORY	0.442258	177,478	78,491	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.414056	26,724	11,065	62.00
65.00	06500	RESPIRATORY THERAPY	0.504958	122,976	62,098	65.00
66.00	06600	PHYSICAL THERAPY	0.368810	51,272	18,910	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.290472	26,970	7,834	67.00
68.00	06800	SPEECH PATHOLOGY	0.300649	5,707	1,716	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.895903	78,498	70,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.958935	1,727	1,656	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.445209	316,807	141,045	73.00
76.00	03480	INFUSION THERAPY	0.451907	347	157	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FORT BRANCH RHC	0.000000		0	88.00
88.01	08801	CLARK & WELLS RHC	0.000000		0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	0.060476	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.620987	0	0	90.03
91.00	09100	EMERGENCY	0.716562	29,040	20,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.815295	5,209	9,456	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		985,890	461,007	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)		985,890		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3

Component CCN: 15-Z319 | Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.398253	6,000	2,390	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194134	16,983	3,297	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.465877	0	0	54.03
60.00	06000	LABORATORY	0.442258	116,595	51,565	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.414056	1,947	806	62.00
65.00	06500	RESPIRATORY THERAPY	0.504958	134,764	68,050	65.00
66.00	06600	PHYSICAL THERAPY	0.368810	425,263	156,841	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.290472	228,884	66,484	67.00
68.00	06800	SPEECH PATHOLOGY	0.300649	32,087	9,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.895903	81,723	73,216	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.958935	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.445209	490,048	218,174	73.00
76.00	03480	INFUSION THERAPY	0.451907	1,450	655	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FORT BRANCH RHC	0.000000		0	88.00
88.01	08801	CLARK & WELLS RHC	0.000000		0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	0.060476	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.620987	0	0	90.03
91.00	09100	EMERGENCY	0.716562	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.815295	585	1,062	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,536,329	652,187	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,536,329		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 4/28/2021 8:15 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		14,404		30.00
31.00	03100	INTENSIVE CARE UNIT		1,824		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.398253	6,293	2,506	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194134	7,776	1,510	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.465877	594	277	54.03
60.00	06000	LABORATORY	0.442258	17,395	7,693	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.414056	331	137	62.00
65.00	06500	RESPIRATORY THERAPY	0.504958	7,744	3,910	65.00
66.00	06600	PHYSICAL THERAPY	0.368810	514	190	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.290472	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.300649	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.895903	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.958935	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.445209	0	0	73.00
76.00	03480	INFUSION THERAPY	0.451907	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	FORT BRANCH RHC	1.259171	0	0	88.00
88.01	08801	CLARK & WELLS RHC	1.036068	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DIABETES	0.060476	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.620987	0	0	90.03
91.00	09100	EMERGENCY	0.716562	6,661	4,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.815295	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		47,308	20,996	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)		47,308		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E Part B Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,892,659	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)	6,892,659	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)	6,961,586	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)	33,468	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,630,331	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,297,787	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,297,787	30.00
31.00	Primary payer payments	1,143	31.00
32.00	Subtotal (line 30 minus line 31)	4,296,644	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)	277,786	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	180,561	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	276,135	36.00
37.00	Subtotal (see instructions)	4,477,205	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,477,205	40.00
40.01	Sequestration adjustment (see instructions)	51,936	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	4,260,089	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)	165,180	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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-1 Part I Date/Time Prepared: 4/28/2021 8:15 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		770,344		4,260,089	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		770,344		4,260,089	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		508,322		165,180	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,278,666		4,425,269	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: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,896,377		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,896,377		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		1,107,582		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,003,959		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: 15-1319	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/28/2021 8:15 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: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-2 | Date/Time Prepared: 4/28/2021 8:15 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,413,236	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)	658,709	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	1,055	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)	3,071,945	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,071,945	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)	3,071,945	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	32,731	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	3,039,214	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)	3,039,214	0	19.00
19.01	Sequestration adjustment (see instructions)	35,255	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	1,896,377	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)	1,107,582	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 4/28/2021 8:15 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,384,368	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)	1,384,368	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,398,212	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)	1,398,212	19.00
20.00	Deductibles (exclude professional component)	110,308	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,287,904	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,287,904	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,875	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,769	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,511	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,293,673	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,293,673	30.00
30.01	Sequestration adjustment (see instructions)	15,007	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	770,344	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)	508,322	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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-3 Part VII | Date/Time Prepared: 4/28/2021 8:15 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	62,347		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)	62,347	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)	62,347	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	16,228		8.00
9.00	Ancillary service charges	47,308	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)	63,536	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)	63,536	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,189	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)	62,347	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)	62,347	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)	62,347	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)	62,347	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	62,347	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)	62,347	0	40.00
41.00	Interim payments	35,766	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	26,581	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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G | Date/Time Prepared: 4/28/2021 8:15 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	11,062,325	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	6,310,059	0	0	0	4.00
5.00	Other receivable	790,580	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,342,829	0	0	0	6.00
7.00	Inventory	725,941	0	0	0	7.00
8.00	Prepaid expenses	672,033	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,218,109	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	421,244	0	0	0	12.00
13.00	Land improvements	258,790	0	0	0	13.00
14.00	Accumulated depreciation	-192,820	0	0	0	14.00
15.00	Buildings	20,557,040	0	0	0	15.00
16.00	Accumulated depreciation	-13,224,880	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,808,455	0	0	0	19.00
20.00	Accumulated depreciation	-3,846,085	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	15,104,168	0	0	0	23.00
24.00	Accumulated depreciation	-9,233,700	0	0	0	24.00
25.00	Minor equipment depreciable	1,256,504	0	0	0	25.00
26.00	Accumulated depreciation	-777,204	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)	16,131,512	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,618,180	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,618,180	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,967,801	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,874,983	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,001,826	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,111,313	0	0	0	40.00
41.00	Deferred income	4,347,609	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	5,643,280	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,979,011	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,271,242	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,271,242	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	27,250,253	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	8,717,548				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)	8,717,548	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,967,801	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-1 | Date/Time Prepared: 4/28/2021 8:15 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		10,283,001		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,565,453				2.00
3.00	Total (sum of line 1 and line 2)		8,717,548		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)		8,717,548		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)		8,717,548		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: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/28/2021 8:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,049,038		2,049,038	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	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,049,038		2,049,038	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	86,649		86,649	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)	86,649		86,649	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,135,687		2,135,687	17.00
18.00	Ancillary services	4,556,876	42,387,693	46,944,569	18.00
19.00	Outpatient services	257,307	8,365,256	8,622,563	19.00
20.00	FORT BRANCH RHC	0	397,482	397,482	20.00
20.01	CLARK & WELLS RHC	0	437,900	437,900	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		841,639	841,639	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MOB	0	7,188,374	7,188,374	27.00
27.01	SNF PERRY CO	0	0	0	27.01
27.02	PRO FEES	0	0	0	27.02
27.03	PROFESSIONAL	0	664,553	664,553	27.03
27.04	199	0	6,678	6,678	27.04
27.05	TELE BH	0	7,490	7,490	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,949,870	60,297,065	67,246,935	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,246,103		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)		36,246,103		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-3 | Date/Time Prepared: 4/28/2021 8:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,246,935	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,591,255	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,655,680	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,246,103	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,590,423	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	463,791	6.00
7.00	Income from investments	52,326	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	112,360	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	63,921	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	267,976	24.00
24.50	COVID-19 PHE Funding	64,596	24.50
25.00	Total other income (sum of lines 6-24)	1,024,970	25.00
26.00	Total (line 5 plus line 25)	-1,565,453	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)	-1,565,453	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H | Date/Time Prepared: 4/28/2021 8:15 am

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		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	96,889	21,143	43,760	0	74,542	236,334	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	248,036	54,127	0	0	0	302,163	6.00
7.00	Physical Therapy	57,706	12,593	0	0	0	70,299	7.00
8.00	Occupational Therapy	20,697	4,517	0	0	0	25,214	8.00
9.00	Speech Pathology	5,913	1,290	0	0	0	7,203	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	30,618	6,682	0	0	0	37,300	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	205	205	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)	459,859	100,352	43,760	0	74,747	678,718	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	29,643	265,977	0	265,977			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	302,163	0	302,163			6.00
7.00	Physical Therapy	0	70,299	0	70,299			7.00
8.00	Occupational Therapy	0	25,214	0	25,214			8.00
9.00	Speech Pathology	0	7,203	0	7,203			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	37,300	0	37,300			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	-205	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)	29,438	708,156	0	708,156			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: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-1 Part I | Date/Time Prepared: 4/28/2021 8:15 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		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	265,977	0	0	0	0	265,977	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	302,163	0	0	0	0	302,163	6.00
7.00	Physical Therapy	70,299	0	0	0	0	70,299	7.00
8.00	Occupational Therapy	25,214	0	0	0	0	25,214	8.00
9.00	Speech Pathology	7,203	0	0	0	0	7,203	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	37,300	0	0	0	0	37,300	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)	708,156	0	0	0	0	708,156	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	265,977		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	181,755	483,918	6.00
7.00	Physical Therapy	42,286	112,585	7.00
8.00	Occupational Therapy	15,167	40,381	8.00
9.00	Speech Pathology	4,333	11,536	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	22,436	59,736	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)		708,156	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-1 Part II | Date/Time Prepared: 4/28/2021 8:15 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	-265,977	442,179	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	302,163	6.00
7.00	Physical Therapy	0	0	0	0	0	70,299	7.00
8.00	Occupational Therapy	0	0	0	0	0	25,214	8.00
9.00	Speech Pathology	0	0	0	0	0	7,203	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	37,300	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	-265,977	442,179	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		265,977	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.601514	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1319 HHA CCN: 15-7445

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

Worksheet H-2 Part I Date/Time Prepared: 4/28/2021 8:15 am

Home Health Agency I

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	13,840	0	81,185	95,025	29,364	1.00
2.00	Skilled Nursing Care	483,918	0	0	0	483,918	149,536	2.00
3.00	Physical Therapy	112,585	0	0	0	112,585	34,790	3.00
4.00	Occupational Therapy	40,381	0	0	0	40,381	12,478	4.00
5.00	Speech Pathology	11,536	0	0	0	11,536	3,565	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	59,736	0	0	0	59,736	18,459	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)	708,156	13,840	0	81,185	803,181	248,192	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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	33,525	0	8,388	0	30,942	42,646	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)	33,525	0	8,388	0	30,942	42,646	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: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-2 Part I | Date/Time Prepared: 4/28/2021 8:15 am

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	Cost Center Description	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	3,283	0	8,926	252,099	0	252,099	1.00
2.00	Skilled Nursing Care	0	0	0	633,454	0	633,454	2.00
3.00	Physical Therapy	0	0	0	147,375	0	147,375	3.00
4.00	Occupational Therapy	0	0	0	52,859	0	52,859	4.00
5.00	Speech Pathology	0	0	0	15,101	0	15,101	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	78,195	0	78,195	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)	3,283	0	8,926	1,179,083	0	1,179,083	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

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	172,271	805,725	2.00
3.00	Physical Therapy	40,080	187,455	3.00
4.00	Occupational Therapy	14,375	67,234	4.00
5.00	Speech Pathology	4,107	19,208	5.00
6.00	Medical Social Services	0	0	6.00
7.00	Home Health Aide	21,266	99,461	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
19.50	Telemedicine	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	252,099	1,179,083	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.	0.271956		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: 15-1319 HHA CCN: 15-7445

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

Worksheet H-2 Part II Date/Time Prepared: 4/28/2021 8:15 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	505	505	459,861	0	95,025	505	1.00
2.00	Skilled Nursing Care	0	0	0	0	483,918	0	2.00
3.00	Physical Therapy	0	0	0	0	112,585	0	3.00
4.00	Occupational Therapy	0	0	0	0	40,381	0	4.00
5.00	Speech Pathology	0	0	0	0	11,536	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	59,736	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)	505	505	459,861		803,181	505	20.00
21.00	Total cost to be allocated	13,840	0	81,185		248,192	33,525	21.00
22.00	Unit cost multiplier	27.405941	0.000000	0.176542		0.309011	66.386139	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSE SALARIES)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	505	0	459,861	267,659	13,717	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)	0	505	0	459,861	267,659	13,717	20.00
21.00	Total cost to be allocated	0	8,388	0	30,942	42,646	3,283	21.00
22.00	Unit cost multiplier	0.000000	16.609901	0.000000	0.067286	0.159330	0.239338	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1319
HHA CCN: 15-7445

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

Worksheet H-2 Part II
Date/Time Prepared: 4/28/2021 8:15 am

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATIENT REVENUE)				
		15.00	16.00				
1.00	Administrative and General	0	841,639				1.00
2.00	Skilled Nursing Care	0	0				2.00
3.00	Physical Therapy	0	0				3.00
4.00	Occupational Therapy	0	0				4.00
5.00	Speech Pathology	0	0				5.00
6.00	Medical Social Services	0	0				6.00
7.00	Home Health Aide	0	0				7.00
8.00	Supplies (see instructions)	0	0				8.00
9.00	Drugs	0	0				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	0	0				18.00
19.00	All Others (specify)	0	0				19.00
19.50	Telemedicine	0	0				19.50
20.00	Total (sum of lines 1-19)	0	841,639				20.00
21.00	Total cost to be allocated	0	8,926				21.00
22.00	Unit cost multiplier	0.000000	0.010605				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-3 Part I Date/Time Prepared: 4/28/2021 8:15 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	805,725		805,725	2,673	301.43	1.00
2.00	Physical Therapy	3.00	187,455	0	187,455	1,737	107.92	2.00
3.00	Occupational Therapy	4.00	67,234	0	67,234	623	107.92	3.00
4.00	Speech Pathology	5.00	19,208	0	19,208	178	107.91	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	99,461		99,461	287	346.55	6.00
7.00	Total (sum of lines 1-6)		1,179,083	0	1,179,083	5,498		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	1,603			8.00
9.00	Physical Therapy		99915	0	1,117			9.00
10.00	Occupational Therapy		99915	0	376			10.00
11.00	Speech Pathology		99915	0	150			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	230			13.00
14.00	Total (sum of lines 8-13)			0	3,476			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	1,603		0	483,192		1.00
2.00	Physical Therapy	0	1,117		0	120,547		2.00
3.00	Occupational Therapy	0	376		0	40,578		3.00
4.00	Speech Pathology	0	150		0	16,187		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	230		0	79,707		6.00
7.00	Total (sum of lines 1-6)	0	3,476		0	740,211		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-3 Part I | Date/Time Prepared: 4/28/2021 8:15 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			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	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	0	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	483,192						1.00
2.00	Physical Therapy	120,547						2.00
3.00	Occupational Therapy	40,578						3.00
4.00	Speech Pathology	16,187						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	79,707						6.00
7.00	Total (sum of lines 1-6)	740,211						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: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-3 Part II | Date/Time Prepared: 4/28/2021 8:15 am

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	0.368810	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.290472	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.300649	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.895903	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.445209	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-4 Part I-II | Date/Time Prepared: 4/28/2021 8:15 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	455,080	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	37,084	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,881	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	483	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	8,852	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	509,380	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	509,380	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	509,380	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	509,380	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	509,380	31.00
31.01	Sequestration adjustment (see instructions)	0	5,692	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	503,688	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: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2019 To 09/30/2020 | Worksheet H-5 | Date/Time Prepared: 4/28/2021 8:15 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		503,688	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		503,688	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		503,688	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: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/28/2021 8:15 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	0	0	0	18,304	18,304	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	121,141	0	121,141	-18,224	102,917	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	27,545	0	27,545	0	27,545	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	148,686	0	148,686	80	148,766	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	22,845	22,845	-22,845	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	22,845	22,845	-22,845	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	148,686	22,845	171,531	-22,765	148,766	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	7,709	7,709	0	7,709	29.00
30.00	Administrative Costs	57,852	112,034	169,886	8,986	178,872	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	57,852	119,743	177,595	8,986	186,581	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	206,538	142,588	349,126	-13,779	335,347	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/28/2021 8:15 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	18,304		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	102,917		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	27,545		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	148,766		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	148,766		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	7,709		29.00
30.00	Administrative Costs	0	178,872		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	186,581		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	335,347		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/28/2021 8:15 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	110,453	0	110,453	0	110,453	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	30,151	0	30,151	18,224	48,375	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	28,335	0	28,335	0	28,335	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	168,939	0	168,939	18,224	187,163	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	67,222	67,222	-67,222	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	67,222	67,222	-67,222	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	168,939	67,222	236,161	-48,998	187,163	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	12,429	79,348	91,777	-20,299	71,478	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	12,429	79,348	91,777	-20,299	71,478	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	181,368	146,570	327,938	-69,297	258,641	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-1 | Date/Time Prepared: 4/28/2021 8:15 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	110,453		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	48,375		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	28,335		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	187,163		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	187,163		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	71,478		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	71,478		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	258,641		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-2 | Date/Time Prepared: 4/28/2021 8:15 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.61	1,629	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.61	1,629		2	1,629	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)	1.61	1,629			1,629	8.00
9.00	Physician Services Under Agreements		133			133	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)					148,766	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)					148,766	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)					186,581	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					165,151	15.00
16.00	Total overhead (sum of lines 14 and 15)					351,732	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					351,732	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					351,732	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					500,498	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2019 To 09/30/2020 | Worksheet M-2 | Date/Time Prepared: 4/28/2021 8:15 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	0.34	1,545	4,200	1,428		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.22	287	2,100	462		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.56	1,832		1,890	1,890	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)	0.56	1,832			1,890	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)					187,163	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)					187,163	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)					71,478	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					195,053	15.00
16.00	Total overhead (sum of lines 14 and 15)					266,531	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					266,531	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					266,531	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					453,694	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/28/2021 8:15 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)		500,498	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		13,905	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		486,593	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,629	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		133	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,762	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		276.16	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)	276.16	276.16	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	234	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	64,621	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	64,621	16.00
16.01	Total program charges (see instructions)(from contractor's records)		51,505	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,465	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,366	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.)		41,230	16.04
16.05	Total program cost (see instructions)	0	50,596	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,717	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,017	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		50,596	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,869	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		54,465	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		54,465	26.00
26.01	Sequestration adjustment (see instructions)		632	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		37,433	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)		16,400	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: 15-1319 Component CCN: 15-8553	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/28/2021 8:15 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)			453,694	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			23,761	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			429,933	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,890	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)			1,890	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			227.48	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)	227.48	227.48		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	416		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	94,632		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	94,632		16.00
16.01	Total program charges (see instructions)(from contractor's records)		91,970		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,685		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,110		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.)		61,413		16.04
16.05	Total program cost (see instructions)	0	76,523		16.05
17.00	Primary payer amounts		32		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,756		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		14,876		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		76,491		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,877		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		85,368		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)		85,368		26.00
26.01	Sequestration adjustment (see instructions)		990		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		35,573		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)		48,805		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: 15-1319 Component CCN: 15-8524	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 8:15 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)	148,766	148,766	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000445	0.002589	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	66	385	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,630	2,052	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,696	2,437	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	148,766	148,766	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	351,732	351,732	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011400	0.016381	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,010	5,762	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,706	8,199	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	11	64	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	518.73	128.11	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	4	14	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,075	1,794	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)		13,905	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)		3,869	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1319 Component CCN: 15-8553	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 8:15 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)	187,163	187,163	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000670	0.001032	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	125	193	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	7,112	2,372	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,237	2,565	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	187,163	187,163	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	266,531	266,531	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.038667	0.013705	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,306	3,653	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	17,543	6,218	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	48	74	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	365.48	84.03	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	19	23	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	6,944	1,933	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)		23,761	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)		8,877	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 8:15 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		37,433	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)		37,433	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		16,400	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		53,833	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: 15-1319 Component CCN: 15-8553	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 8:15 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		35,573	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)		35,573	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		48,805	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		84,378	7.00

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