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: 15-1333	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/15/2021 2:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/15/2021 Time: 2:27 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PUTNAM COUNTY HOSPITAL (15-1333) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[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) DENNIS WEATHERFORD
Officer or Administrator of Provider(s)

CEO
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	358,354	760,384	0	24,768	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	33,713	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	PUTNAM PEDIATRICS AND INTERNAL MED	0		69,129		0	10.00
10.01	FAMILY MEDICINE OF CLOVERDALE II	0		51,199		0	10.01
10.02	NORTH PUTNAM FAMILY HEALTHCARE III	0		92,143		0	10.02
200.00	Total	0	392,067	972,855	0	24,768	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 2:27 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1542 SOUTH BLOOMINGTON ST	PO Box:			1.00
2.00	City: GREENCASTLE	State: IN	Zip Code: 46135-	County: PUTNAM	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	PUTNAM COUNTY HOSPITAL	151333	26900	1	12/31/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PUTNAM COUNTY HOSPITAL	15Z333	26900		12/31/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	PPIM	158515	26900		02/23/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	FMC	158513	26900		02/25/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	NPFH	158514	26900		03/17/2015	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/15/2021 2:27 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 2:27 pm

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 2:27 pm

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

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

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

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

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		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)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

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				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	217,630	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N			122.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 2:27 pm

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

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

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1333	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/15/2021 2:27 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/15/2021 2:27 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/18/2020	Y	03/18/2020	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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/15/2021 2:27 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	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.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1333	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/15/2021 2:27 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/15/2021 2:27 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	19	6,954	44,928.00	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)		19	6,954	44,928.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,196	7,752.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	52,680.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	PUTNAM PEDIATRICS AND INTERNAL MED	88.00				0	26.00
26.01	FAMILY MEDICINE OF CLOVERDALE	88.01				0	26.01
26.02	NORTH PUTNAM FAMILY HEALTHCARE	88.02				0	26.02
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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/15/2021 2:27 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	905	42	1,872			1.00
2.00	HMO and other (see instructions)	0	0				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	125	0	165			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,030	42	2,051			7.00
8.00	INTENSIVE CARE UNIT	133	0	323			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1,163	42	2,374	0.00	245.96	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	PUTNAM PEDIATRICS AND INTERNAL MED	919	3,088	9,695	0.00	13.72	26.00
26.01	FAMILY MEDICINE OF CLOVERDALE	1,258	3,060	9,821	0.00	15.08	26.01
26.02	NORTH PUTNAM FAMILY HEALTHCARE	1,290	2,359	7,802	0.00	13.80	26.02
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	288.56	27.00
28.00	Observation Bed Days		0	634			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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/15/2021 2:27 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	298	7	673	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	246.55	0	298	7	673	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	PUTNAM PEDIATRICS AND INTERNAL MED	13.72					26.00
26.01	FAMILY MEDICINE OF CLOVERDALE	15.08					26.01
26.02	NORTH PUTNAM FAMILY HEALTHCARE	13.21					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	288.56					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/15/2021 2:27 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1542 S. BLOOMINGTON STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GREENCASTLE		IN	46135	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		PUTNAM				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: 15-1333
Component CCN: 15-8515

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

Worksheet S-8
Date/Time Prepared:
7/15/2021 2:27 pm

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: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/15/2021 2:27 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			51 E. MARKET STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CLOVERDALE		IN	46120	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	18:00	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		PUTNAM				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	18:00	08:00	18:00	08:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1333
Component CCN: 15-8513

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

Worksheet S-8

Date/Time Prepared:
7/15/2021 2:27 pm

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	18:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-8 | Date/Time Prepared: 7/15/2021 2:27 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			440 E. PAT RADY WAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BAINBRIDGE		IN	46105	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		PUTNAM				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: 15-1333
Component CCN: 15-8514

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

Worksheet S-8

Date/Time Prepared:
7/15/2021 2:27 pm

RHC III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/15/2021 2:27 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.403569	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,510,232	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	15,560,821	6.00
7.00	Medicaid cost (line 1 times line 6)	6,279,865	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,769,633	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,769,633	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)	9,354,904	0	9,354,904	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,775,349	0	3,775,349	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)	3,775,349	0	3,775,349	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)	6,950,707	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	457,114	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	703,252	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,247,455	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,767,417	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,542,766	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,312,399	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,229,157	2,229,157	437,871	2,667,028	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	68,728	5,554,397	5,623,125	0	5,623,125	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,927,796	5,437,809	8,365,605	-84,786	8,280,819	5.00
7.00	00700	OPERATION OF PLANT	344,451	995,758	1,340,209	32,529	1,372,738	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,820	182,543	213,363	0	213,363	8.00
9.00	00900	HOUSEKEEPING	447,938	83,632	531,570	0	531,570	9.00
10.00	01000	DIETARY	407,006	569,132	976,138	-693,268	282,870	10.00
11.00	01100	CAFETERIA	0	0	0	693,268	693,268	11.00
13.00	01300	NURSING ADMINISTRATION	110,531	39,818	150,349	0	150,349	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,842	127,999	388,841	0	388,841	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	100,923	7,193	108,116	0	108,116	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,160,333	283,243	2,443,576	-6,643	2,436,933	30.00
31.00	03100	INTENSIVE CARE UNIT	721,930	232,981	954,911	-38,376	916,535	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	735,843	791,612	1,527,455	-129,207	1,398,248	50.00
51.00	05100	RECOVERY ROOM	47,129	23,983	71,112	0	71,112	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	819,435	43,349	862,784	0	862,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,098,985	336,397	1,435,382	0	1,435,382	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	137,322	137,322	0	137,322	54.01
54.02	03480	ONCOLOGY	320,298	3,405,298	3,725,596	0	3,725,596	54.02
57.00	05700	CT SCAN	178,892	240,316	419,208	0	419,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	791,681	1,728,259	2,519,940	0	2,519,940	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	426,448	148,519	574,967	0	574,967	65.00
66.00	06600	PHYSICAL THERAPY	0	492,028	492,028	0	492,028	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,569	108,569	0	108,569	67.00
68.00	06800	SPEECH PATHOLOGY	0	45,480	45,480	0	45,480	68.00
69.00	06900	ELECTROCARDIOLOGY	60,733	89,182	149,915	0	149,915	69.00
69.01	06901	CARDIAC REHAB	249,825	6,852	256,677	0	256,677	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,471	11,480	35,951	-35,951	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	210,187	210,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,055	1,023,890	1,349,945	0	1,349,945	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	1,433,736	342,679	1,776,415	-96,246	1,680,169	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	1,169,018	395,559	1,564,577	-96,651	1,467,926	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	1,156,295	367,315	1,523,610	-85,964	1,437,646	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	402,908	53,838	456,746	-1,174	455,572	90.01
91.00	09100	EMERGENCY	3,160,248	1,605,096	4,765,344	-10	4,765,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,983,298	27,140,685	47,123,983	105,579	47,229,562	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,344,375	1,104,123	4,448,498	-96,161	4,352,337	192.00
192.01	19201	JOHNSON/NICHOLS WIC	265,989	48,872	314,861	-9,418	305,443	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	0	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	23,593,662	28,293,680	51,887,342	0	51,887,342	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-150,502	2,516,526		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,942	5,617,183		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,175,442	6,105,377		5.00
7.00	00700	OPERATION OF PLANT	-8,678	1,364,060		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,363		8.00
9.00	00900	HOUSEKEEPING	0	531,570		9.00
10.00	01000	DIETARY	0	282,870		10.00
11.00	01100	CAFETERIA	-44,507	648,761		11.00
13.00	01300	NURSING ADMINISTRATION	0	150,349		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-264	388,577		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
17.01	01701	UTILIZATION REVIEW	0	108,116		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,100,483	1,336,450		30.00
31.00	03100	INTENSIVE CARE UNIT	0	916,535		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,398,248		50.00
51.00	05100	RECOVERY ROOM	0	71,112		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-712,916	149,868		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,440	1,433,942		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	137,322		54.01
54.02	03480	ONCOLOGY	0	3,725,596		54.02
57.00	05700	CT SCAN	0	419,208		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,519,940		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	574,967		65.00
66.00	06600	PHYSICAL THERAPY	0	492,028		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,569		67.00
68.00	06800	SPEECH PATHOLOGY	0	45,480		68.00
69.00	06900	ELECTROCARDIOLOGY	0	149,915		69.00
69.01	06901	CARDIAC REHAB	-208	256,469		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	210,187		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-28,417	1,321,528		73.00
73.01	03950	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	-255	1,679,914		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	-75,000	1,392,926		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	-19,992	1,417,654		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	RHEUMATOLOGY	-249,985	205,587		90.01
91.00	09100	EMERGENCY	-2,421,270	2,344,064		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,995,301	40,234,261		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,352,337		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	305,443		192.01
192.02	19203	RHEUMATOLOGY	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	DME	0	0		193.01
193.02	19302	LACTATION CONSULTING	0	0		193.02
193.03	19303	DIABETIC COUNSELING	0	0		193.03
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	0		194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,995,301	44,892,041		200.00

RECLASSIFICATIONS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/15/2021 2:27 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CLINIC RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	340,637		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,398		2.00
3.00	OPERATION OF PLANT	7.00	0	32,529		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	377,564		
	C - CAFE RECLASS					
1.00	CAFETERIA	11.00	289,062	404,206		1.00
	0		289,062	404,206		
	D - INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	82,194		1.00
	0		0	82,194		
	E - PPO DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	15,040		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	15,040		
	F - IMPLANTABLES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	210,187		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
	0		0	210,187		
	G - MED SUPPLY COST RECLASS					
1.00	OPERATING ROOM	50.00	24,471	11,480		1.00
	0		24,471	11,480		
500.00	Grand Total: Increases		313,533	1,100,671		500.00

RECLASSIFICATIONS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/15/2021 2:27 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CLINIC RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,990	9	1.00
2.00	PUTNAM PEDIATRICS AND INTERNAL MED	88.00	0	93,483	0	2.00
3.00	FAMILY MEDICINE OF CLOVERDALE	88.01	0	92,595	0	3.00
4.00	NORTH PUTNAM FAMILY HEALTHCARE	88.02	0	84,771	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	92,779	0	5.00
6.00	JOHNSON/NICHOLS WIC	192.01	0	6,946	0	6.00
	0		0	377,564		
	C - CAFE RECLASS					
1.00	DIETARY	10.00	289,062	404,206	0	1.00
	0		289,062	404,206		
	D - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	82,194	13	1.00
	0		0	82,194		
	E - PPO DEPRECIATION					
1.00	PUTNAM PEDIATRICS AND INTERNAL MED	88.00	0	2,763	9	1.00
2.00	FAMILY MEDICINE OF CLOVERDALE	88.01	0	4,056	0	2.00
3.00	NORTH PUTNAM FAMILY HEALTHCARE	88.02	0	1,193	0	3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,382	0	4.00
5.00	JOHNSON/NICHOLS WIC	192.01	0	2,472	0	5.00
6.00	RHEUMATOLOGY	90.01	0	1,174	0	6.00
	0		0	15,040		
	F - IMPLANTABLES					
1.00	ADULTS & PEDIATRICS	30.00	0	6,643	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	38,376	0	2.00
3.00	OPERATING ROOM	50.00	0	165,158	0	3.00
4.00	EMERGENCY	91.00	0	10	0	4.00
	0		0	210,187		
	G - MED SUPPLY COST RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	24,471	11,480	0	1.00
	0		24,471	11,480		
500.00	Grand Total: Decreases		313,533	1,100,671		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/15/2021 2:27 pm

		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	182,502	0	0	0	0	1.00
2.00	Land Improvements	369,154	35,741	0	35,741	0	2.00
3.00	Buildings and Fixtures	33,176,888	1,833,672	0	1,833,672	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	24,590,930	317,580	0	317,580	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	58,319,474	2,186,993	0	2,186,993	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	58,319,474	2,186,993	0	2,186,993	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	182,502	0	1.00
2.00	Land Improvements	404,895	0	2.00
3.00	Buildings and Fixtures	35,010,560	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	24,908,510	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,506,467	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	60,506,467	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/15/2021 2:27 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,827,305	0	401,852	0	0	1.00
3.00	Total (sum of lines 1-2)	1,827,305	0	401,852	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,229,157		1.00
3.00	Total (sum of lines 1-2)	0	2,229,157		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 7/15/2021 2:27 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	60,506,467	0	60,506,467	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	60,506,467	0	60,506,467	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,182,982	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,182,982	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	251,350	0	82,194	0	2,516,526	1.00
3.00	Total (sum of lines 1-2)	251,350	0	82,194	0	2,516,526	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/15/2021 2:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,452,893			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-44,507	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/15/2021 2:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MEDICAL RECORDS FEES	B	-264	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	SILVER RECOVERY	B	-1,440	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	PHARM - MISC REVENUE	B	-866	DRUGS CHARGED TO PATIENTS	73.00	0	33.02
33.03	VEND REBATE/REF	B	-3,278	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHARMACY REBATES	B	-27,551	DRUGS CHARGED TO PATIENTS	73.00	0	33.04
33.05	OTHER MISC INCOME	B	-39,034	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	NON-ALLOWABLE INTEREST EXPENSE	A	-40,409	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.06
33.07	LOBBYING OFFSET	A	-982	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	ADVERTISING OFFSET	A	-29,942	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ADVERTISING OFFSET	A	-208	CARDIAC REHAB	69.01	0	33.09
33.10	ADVERTISING OFFSET	A	-255	PUTNAM PEDIATRICS AND INTERNAL MED	88.00	0	33.10
33.11	ADVERTISING OFFSET	A	-7,992	NORTH PUTNAM FAMILY HEALTHCARE	88.02	0	33.11
33.12	COMMUNITY RELATIONS OFFSET	A	-144,873	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	COMMUNITY RELATIONS OFFSET	A	-5,705	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	TELEPHONE WAGES	A	-985	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	TELEPHONE BENEFITS	A	-237	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	TELEPHONE OTHER	A	-1,082	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	TELEVISION OFFSET	A	-8,678	OPERATION OF PLANT	7.00	0	33.17
33.19	PHYSICIAN RECRUITMENT	A	-12,000	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	PHYSICIAN RECRUITMENT	A	-75,000	FAMILY MEDICINE OF CLOVERDALE	88.01	0	33.20
33.21	PHYSICIAN RECRUITMENT	A	-12,000	NORTH PUTNAM FAMILY HEALTHCARE	88.02	0	33.21
33.22	PHYSICIAN RECRUITMENT	A	-19,761	EMERGENCY	91.00	0	33.22
33.24	HAF EXPENSE	A	-1,955,266	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	INTEREST INCOME	B	-110,093	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,995,301				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/15/2021 2:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,948,333	2,401,509	546,824	0	0	1.00
2.00	73.01	ONCOLOGY	122,125	0	122,125	0	0	2.00
3.00	60.00	LABORATORY	36,000	0	36,000	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	1,088,483	1,088,483	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	819,435	712,916	106,519	0	0	5.00
6.00	90.01	RHEUMATOLOGY	249,985	249,985	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			5,264,361	4,452,893	811,468		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	73.01	ONCOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	90.01	RHEUMATOLOGY	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	91.00	EMERGENCY	0	0	0	2,401,509		1.00
2.00	73.01	ONCOLOGY	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,088,483		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	712,916		5.00
6.00	90.01	RHEUMATOLOGY	0	0	0	249,985		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	4,452,893		200.00

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Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					307	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					187	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	4,897.00	1,547.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	85.39	64.04	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.70	42.70	32.02			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					418,155	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					99,070	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					517,225	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					517,225	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					517,225	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					13,109	24.00
25.00	Assistants (line 4 times column 3, line 11)					5,988	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					19,097	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					19,097	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					19,097	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	85.39	64.04	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	517,225		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	19,097		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	536,322		63.00
64.00	Total cost of outside supplier services (from your records)	419,883		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	19,097		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	19,097		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		257	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,563.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.95	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.48	40.48	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	126,525	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	126,525	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	126,525	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	126,525	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	10,403	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	10,403	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	10,403	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	10,403	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.95	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		126,525	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		10,403	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		136,928	63.00
64.00	Total cost of outside supplier services (from your records)		108,286	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		10,403	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		10,403	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

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Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					141	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	716.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.80	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.90	38.90	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					55,705	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					55,705	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					55,705	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					77.80	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					60,684	22.00
23.00	Total salary equivalency (see instructions)					60,684	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					5,485	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					5,485	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,485	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,485	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/15/2021 2:27 pm

Speech Pathology — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.80	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	60,684		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,485		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	66,169		63.00
64.00	Total cost of outside supplier services (from your records)	45,360		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	5,485		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,485		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,516,526	2,516,526				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,617,183	3,552	5,620,735			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,105,377	330,171	699,530	7,135,078	7,135,078	5.00
7.00	00700	OPERATION OF PLANT	1,364,060	240,163	82,299	1,686,522	318,709	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	213,363	15,694	7,364	236,421	44,677	8.00
9.00	00900	HOUSEKEEPING	531,570	14,672	107,024	653,266	123,450	9.00
10.00	01000	DIETARY	282,870	81,184	28,180	392,234	74,122	10.00
11.00	01100	CAFETERIA	648,761	37,237	69,065	755,063	142,687	11.00
13.00	01300	NURSING ADMINISTRATION	150,349	15,438	26,409	192,196	36,320	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	388,577	91,747	62,322	542,646	102,546	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	108,116	7,731	24,113	139,960	26,449	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,336,450	137,899	516,162	1,990,511	376,155	30.00
31.00	03100	INTENSIVE CARE UNIT	916,535	65,955	172,489	1,154,979	218,261	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,398,248	189,925	181,660	1,769,833	334,452	50.00
51.00	05100	RECOVERY ROOM	71,112	53,279	11,260	135,651	25,635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	149,868	0	195,785	345,653	65,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,433,942	70,366	262,577	1,766,885	333,895	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	137,322	3,250	0	140,572	26,564	54.01
54.02	03480	ONCOLOGY	3,725,596	112,757	76,528	3,914,881	739,811	54.02
57.00	05700	CT SCAN	419,208	30,644	42,742	492,594	93,087	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,519,940	58,271	189,154	2,767,365	522,960	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	574,967	16,251	101,890	693,108	130,979	65.00
66.00	06600	PHYSICAL THERAPY	492,028	39,559	0	531,587	100,456	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,569	0	0	108,569	20,517	67.00
68.00	06800	SPEECH PATHOLOGY	45,480	0	0	45,480	8,595	68.00
69.00	06900	ELECTROCARDIOLOGY	149,915	2,322	14,511	166,748	31,511	69.00
69.01	06901	CARDIAC REHAB	256,469	37,516	59,690	353,675	66,835	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	210,187	0	0	210,187	39,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,321,528	20,801	77,903	1,420,232	268,387	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	1,679,914	112,270	342,558	2,134,742	403,411	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	1,392,926	150,900	279,310	1,823,136	344,525	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	1,417,654	150,900	276,270	1,844,824	348,624	88.02
90.00	09000	CLINIC	0	3,761	0	3,761	711	90.00
90.01	09001	RHEUMATOLOGY	205,587	10,934	96,266	312,787	59,109	90.01
91.00	09100	EMERGENCY	2,344,064	134,789	755,069	3,233,922	611,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,234,261	2,239,938	4,758,130	39,095,068	6,039,606	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,074	0	11,074	2,093	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,352,337	249,426	799,053	5,400,816	1,020,609	192.00
192.01	19201	JOHNSON/NICHOLS WIC	305,443	0	63,552	368,995	69,730	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	16,088	0	16,088	3,040	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
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)	44,892,041	2,516,526	5,620,735	44,892,041	7,135,078	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,005,231					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,199	297,297				8.00
9.00	00900	HOUSEKEEPING	15,145	1,668	793,529			9.00
10.00	01000	DIETARY	83,800	1,232	40,488	591,876		10.00
11.00	01100	CAFETERIA	38,437	0	18,571	0	954,758	11.00
13.00	01300	NURSING ADMINISTRATION	15,936	0	7,699	0	4,000	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,703	0	45,756	0	46,850	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	7,980	0	3,855	0	8,917	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	142,342	64,674	68,773	504,780	113,365	30.00
31.00	03100	INTENSIVE CARE UNIT	68,080	49,941	32,893	87,096	64,290	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	196,044	42,203	94,719	0	60,187	50.00
51.00	05100	RECOVERY ROOM	54,996	4,572	26,571	0	2,787	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	19,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,633	22,240	35,093	0	119,573	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	3,355	0	1,621	0	0	54.01
54.02	03480	ONCOLOGY	116,390	9,557	56,234	0	36,180	54.02
57.00	05700	CT SCAN	31,632	0	15,283	0	21,599	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	60,148	0	29,061	0	118,158	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,774	0	8,105	0	40,870	65.00
66.00	06600	PHYSICAL THERAPY	40,834	8,210	19,729	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	2,396	0	1,158	0	7,164	69.00
69.01	06901	CARDIAC REHAB	38,725	0	18,710	0	20,458	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,471	0	10,374	0	30,701	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	115,887	6,655	55,991	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	155,762	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	155,762	0	0	0	0	88.02
90.00	09000	CLINIC	3,882	0	1,876	0	0	90.00
90.01	09001	RHEUMATOLOGY	11,287	0	5,453	0	33,094	90.01
91.00	09100	EMERGENCY	139,131	72,390	67,222	0	164,562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,719,731	283,342	665,235	591,876	912,612	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,431	0	5,523	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	257,462	13,955	114,747	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	42,146	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	16,607	0	8,024	0	0	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,005,231	297,297	793,529	591,876	954,758	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
			13.00	16.00	17.00	17.01	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	256,151					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	832,501				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	187,161		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,855	350,479	0	159,620	3,855,554	30.00
31.00	03100	INTENSIVE CARE UNIT	48,121	0	0	27,541	1,751,202	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	272,419	0	0	2,769,857	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	250,212	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	430,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	2,350,319	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	172,112	54.01
54.02	03480	ONCOLOGY	0	0	0	0	4,873,053	54.02
57.00	05700	CT SCAN	0	0	0	0	654,195	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	259	0	0	3,497,951	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	889,836	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	700,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	129,086	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	54,075	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	208,977	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	498,403	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	249,907	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,751,165	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0	0	2,716,686	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	0	2,323,423	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	0	2,349,210	88.02
90.00	09000	CLINIC	0	0	0	0	10,230	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	421,730	90.01
91.00	09100	EMERGENCY	123,175	209,344	0	0	4,620,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	256,151	832,501	0	187,161	37,529,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	30,121	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	6,807,589	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	480,871	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	43,759	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	256,151	832,501	0	187,161	44,892,041	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	UTILIZATION REVIEW				17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,855,554		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,751,202		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,769,857		50.00
51.00	05100	RECOVERY ROOM	0	250,212		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	430,829		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,350,319		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	172,112		54.01
54.02	03480	ONCOLOGY	0	4,873,053		54.02
57.00	05700	CT SCAN	0	654,195		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	3,497,951		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	889,836		65.00
66.00	06600	PHYSICAL THERAPY	0	700,816		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	129,086		67.00
68.00	06800	SPEECH PATHOLOGY	0	54,075		68.00
69.00	06900	ELECTROCARDIOLOGY	0	208,977		69.00
69.01	06901	CARDIAC REHAB	0	498,403		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	249,907		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,751,165		73.00
73.01	03950	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	2,716,686		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	2,323,423		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	2,349,210		88.02
90.00	09000	CLINIC	0	10,230		90.00
90.01	09001	RHEUMATOLOGY	0	421,730		90.01
91.00	09100	EMERGENCY	0	4,620,873		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	37,529,701		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,121		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,807,589		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	480,871		192.01
192.02	19203	RHEUMATOLOGY	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	DME	0	0		193.01
193.02	19302	LACTATION CONSULTING	0	0		193.02
193.03	19303	DIABETIC COUNSELING	0	0		193.03
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	43,759		194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	44,892,041		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,552	3,552	3,552		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	330,171	330,171	442	330,613	5.00
7.00	00700	OPERATION OF PLANT	0	240,163	240,163	52	14,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,694	15,694	5	2,070	8.00
9.00	00900	HOUSEKEEPING	0	14,672	14,672	68	5,720	9.00
10.00	01000	DIETARY	0	81,184	81,184	18	3,434	10.00
11.00	01100	CAFETERIA	0	37,237	37,237	44	6,611	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,438	15,438	17	1,683	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	91,747	91,747	39	4,751	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	7,731	7,731	15	1,225	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	137,899	137,899	326	17,429	30.00
31.00	03100	INTENSIVE CARE UNIT	0	65,955	65,955	109	10,113	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	189,925	189,925	115	15,497	50.00
51.00	05100	RECOVERY ROOM	0	53,279	53,279	7	1,188	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	124	3,027	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	70,366	70,366	166	15,471	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,250	3,250	0	1,231	54.01
54.02	03480	ONCOLOGY	0	112,757	112,757	48	34,279	54.02
57.00	05700	CT SCAN	0	30,644	30,644	27	4,313	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	58,271	58,271	120	24,231	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,251	16,251	64	6,069	65.00
66.00	06600	PHYSICAL THERAPY	0	39,559	39,559	0	4,655	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	951	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	398	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,322	2,322	9	1,460	69.00
69.01	06901	CARDIAC REHAB	0	37,516	37,516	38	3,097	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,801	20,801	49	12,436	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	112,270	112,270	216	18,692	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	150,900	150,900	177	15,963	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	150,900	150,900	175	16,153	88.02
90.00	09000	CLINIC	0	3,761	3,761	0	33	90.00
90.01	09001	RHEUMATOLOGY	0	10,934	10,934	61	2,739	90.01
91.00	09100	EMERGENCY	0	134,789	134,789	477	28,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,239,938	2,239,938	3,008	279,842	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,074	11,074	0	97	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	249,426	249,426	504	47,302	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	40	3,231	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	16,088	16,088	0	141	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
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	2,516,526	2,516,526	3,552	330,613	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	254,982					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,060	19,829				8.00
9.00	00900	HOUSEKEEPING	1,926	111	22,497			9.00
10.00	01000	DIETARY	10,656	82	1,148	96,522		10.00
11.00	01100	CAFETERIA	4,888	0	526	0	49,306	11.00
13.00	01300	NURSING ADMINISTRATION	2,026	0	218	0	207	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,042	0	1,297	0	2,419	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	1,015	0	109	0	460	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,100	4,314	1,950	82,319	5,854	30.00
31.00	03100	INTENSIVE CARE UNIT	8,657	3,331	933	14,203	3,320	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,929	2,815	2,685	0	3,108	50.00
51.00	05100	RECOVERY ROOM	6,993	305	753	0	144	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,025	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,236	1,483	995	0	6,175	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	427	0	46	0	0	54.01
54.02	03480	ONCOLOGY	14,800	637	1,594	0	1,868	54.02
57.00	05700	CT SCAN	4,022	0	433	0	1,115	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,648	0	824	0	6,102	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,133	0	230	0	2,111	65.00
66.00	06600	PHYSICAL THERAPY	5,192	548	559	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	305	0	33	0	370	69.00
69.01	06901	CARDIAC REHAB	4,924	0	530	0	1,057	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,730	0	294	0	1,585	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	14,736	444	1,587	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	19,806	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	19,806	0	0	0	0	88.02
90.00	09000	CLINIC	494	0	53	0	0	90.00
90.01	09001	RHEUMATOLOGY	1,435	0	155	0	1,709	90.01
91.00	09100	EMERGENCY	17,692	4,828	1,906	0	8,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	218,678	18,898	18,858	96,522	47,129	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,453	0	157	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,739	931	3,255	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	2,177	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	2,112	0	227	0	0	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
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)	254,982	19,829	22,497	96,522	49,306	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
			13.00	16.00	17.00	17.01	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	19,589					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	112,295				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	10,555		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,489	47,276	0	9,002	330,958	30.00
31.00	03100	INTENSIVE CARE UNIT	3,680	0	0	1,553	111,854	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	36,746	0	0	275,820	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	62,669	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	4,176	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	103,892	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	4,954	54.01
54.02	03480	ONCOLOGY	0	0	0	0	165,983	54.02
57.00	05700	CT SCAN	0	0	0	0	40,554	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	35	0	0	97,231	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	26,858	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	50,513	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	951	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	398	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	4,499	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	47,162	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	37,895	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0	0	147,945	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	0	186,846	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	0	187,034	88.02
90.00	09000	CLINIC	0	0	0	0	4,341	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	17,033	90.01
91.00	09100	EMERGENCY	9,420	28,238	0	0	234,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,589	112,295	0	10,555	2,145,572	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	12,781	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	334,157	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	5,448	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	18,568	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,589	112,295	0	10,555	2,516,526	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	UTILIZATION REVIEW				17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	330,958		30.00
31.00	03100	INTENSIVE CARE UNIT	0	111,854		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	275,820		50.00
51.00	05100	RECOVERY ROOM	0	62,669		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	4,176		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	103,892		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	4,954		54.01
54.02	03480	ONCOLOGY	0	165,983		54.02
57.00	05700	CT SCAN	0	40,554		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	97,231		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	26,858		65.00
66.00	06600	PHYSICAL THERAPY	0	50,513		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	951		67.00
68.00	06800	SPEECH PATHOLOGY	0	398		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,499		69.00
69.01	06901	CARDIAC REHAB	0	47,162		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,840		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,895		73.00
73.01	03950	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	147,945		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	186,846		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	187,034		88.02
90.00	09000	CLINIC	0	4,341		90.00
90.01	09001	RHEUMATOLOGY	0	17,033		90.01
91.00	09100	EMERGENCY	0	234,166		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,145,572		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,781		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	334,157		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	5,448		192.01
192.02	19203	RHEUMATOLOGY	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	DME	0	0		193.01
193.02	19302	LACTATION CONSULTING	0	0		193.02
193.03	19303	DIABETIC COUNSELING	0	0		193.03
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	18,568		194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,516,526		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	108,399					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	153	23,524,934				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,222	2,927,796	-7,135,078	37,756,963		5.00
7.00	00700	OPERATION OF PLANT	10,345	344,451	0	1,686,522	83,679	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	676	30,820	0	236,421	676	8.00
9.00	00900	HOUSEKEEPING	632	447,938	0	653,266	632	9.00
10.00	01000	DIETARY	3,497	117,944	0	392,234	3,497	10.00
11.00	01100	CAFETERIA	1,604	289,062	0	755,063	1,604	11.00
13.00	01300	NURSING ADMINISTRATION	665	110,531	0	192,196	665	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,952	260,842	0	542,646	3,952	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	333	100,923	0	139,960	333	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,940	2,160,333	0	1,990,511	5,940	30.00
31.00	03100	INTENSIVE CARE UNIT	2,841	721,930	0	1,154,979	2,841	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,181	760,314	0	1,769,833	8,181	50.00
51.00	05100	RECOVERY ROOM	2,295	47,129	0	135,651	2,295	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	819,435	0	345,653	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,031	1,098,985	0	1,766,885	3,031	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	140	0	0	140,572	140	54.01
54.02	03480	ONCOLOGY	4,857	320,298	0	3,914,881	4,857	54.02
57.00	05700	CT SCAN	1,320	178,892	0	492,594	1,320	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,510	791,681	0	2,767,365	2,510	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	700	426,448	0	693,108	700	65.00
66.00	06600	PHYSICAL THERAPY	1,704	0	0	531,587	1,704	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	108,569	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	45,480	0	68.00
69.00	06900	ELECTROCARDIOLOGY	100	60,733	0	166,748	100	69.00
69.01	06901	CARDIAC REHAB	1,616	249,825	0	353,675	1,616	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	210,187	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	896	326,055	0	1,420,232	896	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	4,836	1,433,736	0	2,134,742	4,836	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	6,500	1,169,018	0	1,823,136	6,500	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	6,500	1,156,295	0	1,844,824	6,500	88.02
90.00	09000	CLINIC	162	0	0	3,761	162	90.00
90.01	09001	RHEUMATOLOGY	471	402,908	0	312,787	471	90.01
91.00	09100	EMERGENCY	5,806	3,160,248	0	3,233,922	5,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,485	19,914,570	-7,135,078	31,959,990	71,765	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	0	0	11,074	477	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,744	3,344,375	0	5,400,816	10,744	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	265,989	0	368,995	0	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	693	0	0	16,088	693	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,516,526	5,620,735		7,135,078	2,005,231	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.215399	0.238927		0.188974	23.963372	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		3,552		330,613	254,982	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000151		0.008756	3.047144	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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	178,564					8.00
9.00	00900	HOUSEKEEPING	1,002	68,538				9.00
10.00	01000	DIETARY	740	3,497	2,195			10.00
11.00	01100	CAFETERIA	0	1,604	0	268,534		11.00
13.00	01300	NURSING ADMINISTRATION	0	665	0	1,125	96,251	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,952	0	13,177	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	333	0	2,508	0	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,845	5,940	1,872	31,885	31,885	30.00
31.00	03100	INTENSIVE CARE UNIT	29,996	2,841	323	18,082	18,082	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,348	8,181	0	16,928	0	50.00
51.00	05100	RECOVERY ROOM	2,746	2,295	0	784	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,585	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,358	3,031	0	33,631	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	140	0	0	0	54.01
54.02	03480	ONCOLOGY	5,740	4,857	0	10,176	0	54.02
57.00	05700	CT SCAN	0	1,320	0	6,075	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,510	0	33,233	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	700	0	11,495	0	65.00
66.00	06600	PHYSICAL THERAPY	4,931	1,704	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	100	0	2,015	0	69.00
69.01	06901	CARDIAC REHAB	0	1,616	0	5,754	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	896	0	8,635	0	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	3,997	4,836	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	162	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	471	0	9,308	0	90.01
91.00	09100	EMERGENCY	43,479	5,806	0	46,284	46,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,182	57,457	2,195	256,680	96,251	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	477	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,382	9,911	0	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	11,854	0	192.01
192.02	19203	RHEUMATOLOGY	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	693	0	0	0	194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02
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)	297,297	793,529	591,876	954,758	256,151	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.664932	11.577942	269.647380	3.555445	2.661281	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	19,829	22,497	96,522	49,306	19,589	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.111047	0.328241	43.973576	0.183612	0.203520	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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)		
			16.00	17.00	17.01		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,989				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	2,195		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	43,358	0	1,872		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	323		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	33,701	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.01
54.02	03480	ONCOLOGY	0	0	0		54.02
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	32	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	03950	ONCOLOGY	0	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	RHEUMATOLOGY	0	0	0		90.01
91.00	09100	EMERGENCY	25,898	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,989	0	2,195		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0		192.01
192.02	19203	RHEUMATOLOGY	0	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	DME	0	0	0		193.01
193.02	19302	LACTATION CONSULTING	0	0	0		193.02
193.03	19303	DIABETIC COUNSELING	0	0	0		193.03
194.00	07950	VACANT SPACE	0	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	0	0		194.01
194.02	07952	PUTNAM/HENRY PRENATAL	0	0	0		194.02
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)	832,501	0	187,161		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.083397	0.000000	85.266970		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/15/2021 2:27 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)		
			16.00	17.00	17.01		
204.00		Cost to be allocated (per Wkst. B, Part II)	112,295	0	10,555		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.090359	0.000000	4.808656		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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,855,554		3,855,554	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,751,202		1,751,202	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,769,857		2,769,857	0	0	50.00
51.00	05100	RECOVERY ROOM	250,212		250,212	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	430,829		430,829	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,350,319		2,350,319	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	172,112		172,112	0	0	54.01
54.02	03480	ONCOLOGY	4,873,053		4,873,053	0	0	54.02
57.00	05700	CT SCAN	654,195		654,195	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,497,951		3,497,951	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	889,836	0	889,836	0	0	65.00
66.00	06600	PHYSICAL THERAPY	700,816	0	700,816	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	129,086	0	129,086	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	54,075	0	54,075	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	208,977		208,977	0	0	69.00
69.01	06901	CARDIAC REHAB	498,403		498,403	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	249,907		249,907	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,751,165		1,751,165	0	0	73.00
73.01	03950	ONCOLOGY	0		0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	2,716,686		2,716,686	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	2,323,423		2,323,423	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	2,349,210		2,349,210	0	0	88.02
90.00	09000	CLINIC	10,230		10,230	0	0	90.00
90.01	09001	RHEUMATOLOGY	421,730		421,730	0	0	90.01
91.00	09100	EMERGENCY	4,620,873		4,620,873	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	914,716		914,716		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,444,417	0	38,444,417	0	0	200.00
201.00		Less Observation Beds	914,716		914,716		0	201.00
202.00		Total (see instructions)	37,529,701	0	37,529,701	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,388,115		4,388,115			30.00
31.00	03100	INTENSIVE CARE UNIT	1,448,476		1,448,476			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	544,346	2,815,101	3,359,447	0.824498	0.000000	50.00
51.00	05100	RECOVERY ROOM	63,883	332,323	396,206	0.631520	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	26,484	282,032	308,516	1.396456	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	819,840	7,085,261	7,905,101	0.297317	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	32,644	1,111,922	1,144,566	0.150373	0.000000	54.01
54.02	03480	ONCOLOGY	3,931	8,176,810	8,180,741	0.595674	0.000000	54.02
57.00	05700	CT SCAN	593,046	16,512,531	17,105,577	0.038245	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,532,702	13,497,929	15,030,631	0.232722	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,345,083	741,485	2,086,568	0.426459	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	523,555	1,987,519	2,511,074	0.279090	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,028	325,230	494,258	0.261171	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	44,228	164,319	208,547	0.259294	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	234,494	872,119	1,106,613	0.188844	0.000000	69.00
69.01	06901	CARDIAC REHAB	4,906	597,313	602,219	0.827611	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	130,794	212,688	343,482	0.727569	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,110,936	1,868,898	2,979,834	0.587672	0.000000	73.00
73.01	03950	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	2,061,932	2,061,932			88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	2,139,152	2,139,152			88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	1,543,201	1,543,201			88.02
90.00	09000	CLINIC	0	3,763	3,763	2.718576	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	11,779	11,779	35.803549	0.000000	90.01
91.00	09100	EMERGENCY	334,266	16,231,757	16,566,023	0.278937	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,068,645	1,068,645	0.855959	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,350,757	79,643,709	92,994,466			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,350,757	79,643,709	92,994,466			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.01
54.02	03480	ONCOLOGY	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03950	ONCOLOGY	0.000000		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED			88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE			88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE			88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	RHEUMATOLOGY	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 2:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,855,554		3,855,554	0	3,855,554	30.00
31.00	03100	INTENSIVE CARE UNIT	1,751,202		1,751,202	0	1,751,202	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,769,857		2,769,857	0	2,769,857	50.00
51.00	05100	RECOVERY ROOM	250,212		250,212	0	250,212	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	430,829		430,829	0	430,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,350,319		2,350,319	0	2,350,319	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	172,112		172,112	0	172,112	54.01
54.02	03480	ONCOLOGY	4,873,053		4,873,053	0	4,873,053	54.02
57.00	05700	CT SCAN	654,195		654,195	0	654,195	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,497,951		3,497,951	0	3,497,951	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	889,836	0	889,836	0	889,836	65.00
66.00	06600	PHYSICAL THERAPY	700,816	0	700,816	0	700,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	129,086	0	129,086	0	129,086	67.00
68.00	06800	SPEECH PATHOLOGY	54,075	0	54,075	0	54,075	68.00
69.00	06900	ELECTROCARDIOLOGY	208,977		208,977	0	208,977	69.00
69.01	06901	CARDIAC REHAB	498,403		498,403	0	498,403	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	249,907		249,907	0	249,907	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,751,165		1,751,165	0	1,751,165	73.00
73.01	03950	ONCOLOGY	0		0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	2,716,686		2,716,686	0	2,716,686	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	2,323,423		2,323,423	0	2,323,423	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	2,349,210		2,349,210	0	2,349,210	88.02
90.00	09000	CLINIC	10,230		10,230	0	10,230	90.00
90.01	09001	RHEUMATOLOGY	421,730		421,730	0	421,730	90.01
91.00	09100	EMERGENCY	4,620,873		4,620,873	0	4,620,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	914,716		914,716		914,716	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,444,417	0	38,444,417	0	38,444,417	200.00
201.00		Less Observation Beds	914,716		914,716		914,716	201.00
202.00		Total (see instructions)	37,529,701	0	37,529,701	0	37,529,701	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 2:27 pm

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	4,388,115		4,388,115			30.00
31.00	03100	INTENSIVE CARE UNIT	1,448,476		1,448,476			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	544,346	2,815,101	3,359,447	0.824498	0.000000	50.00
51.00	05100	RECOVERY ROOM	63,883	332,323	396,206	0.631520	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	26,484	282,032	308,516	1.396456	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	819,840	7,085,261	7,905,101	0.297317	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	32,644	1,111,922	1,144,566	0.150373	0.000000	54.01
54.02	03480	ONCOLOGY	3,931	8,176,810	8,180,741	0.595674	0.000000	54.02
57.00	05700	CT SCAN	593,046	16,512,531	17,105,577	0.038245	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,532,702	13,497,929	15,030,631	0.232722	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,345,083	741,485	2,086,568	0.426459	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	523,555	1,987,519	2,511,074	0.279090	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,028	325,230	494,258	0.261171	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	44,228	164,319	208,547	0.259294	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	234,494	872,119	1,106,613	0.188844	0.000000	69.00
69.01	06901	CARDIAC REHAB	4,906	597,313	602,219	0.827611	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	130,794	212,688	343,482	0.727569	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,110,936	1,868,898	2,979,834	0.587672	0.000000	73.00
73.01	03950	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	2,061,932	2,061,932	1.317544	0.000000	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	2,139,152	2,139,152	1.086142	0.000000	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	1,543,201	1,543,201	1.522297	0.000000	88.02
90.00	09000	CLINIC	0	3,763	3,763	2.718576	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	11,779	11,779	35.803549	0.000000	90.01
91.00	09100	EMERGENCY	334,266	16,231,757	16,566,023	0.278937	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,068,645	1,068,645	0.855959	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,350,757	79,643,709	92,994,466			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,350,757	79,643,709	92,994,466			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/15/2021 2:27 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.01
54.02	03480	ONCOLOGY	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03950	ONCOLOGY	0.000000		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000		88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000		88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	RHEUMATOLOGY	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	275,820	3,359,447	0.082103	190,752	15,661	50.00
51.00	05100	RECOVERY ROOM	62,669	396,206	0.158173	22,847	3,614	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,176	308,516	0.013536	11,448	155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,892	7,905,101	0.013142	389,596	5,120	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	4,954	1,144,566	0.004328	22,776	99	54.01
54.02	03480	ONCOLOGY	165,983	8,180,741	0.020289	279	6	54.02
57.00	05700	CT SCAN	40,554	17,105,577	0.002371	280,029	664	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	97,231	15,030,631	0.006469	694,226	4,491	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	26,858	2,086,568	0.012872	580,140	7,468	65.00
66.00	06600	PHYSICAL THERAPY	50,513	2,511,074	0.020116	168,470	3,389	66.00
67.00	06700	OCCUPATIONAL THERAPY	951	494,258	0.001924	69,651	134	67.00
68.00	06800	SPEECH PATHOLOGY	398	208,547	0.001908	20,128	38	68.00
69.00	06900	ELECTROCARDIOLOGY	4,499	1,106,613	0.004066	17,054	69	69.00
69.01	06901	CARDIAC REHAB	47,162	602,219	0.078314	3,908	306	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,840	343,482	0.005357	26,693	143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,895	2,979,834	0.012717	503,304	6,401	73.00
73.01	03950	ONCOLOGY	0	0	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	147,945	2,061,932	0.071751	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	186,846	2,139,152	0.087346	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	187,034	1,543,201	0.121199	0	0	88.02
90.00	09000	CLINIC	4,341	3,763	1.153601	0	0	90.00
90.01	09001	RHEUMATOLOGY	17,033	11,779	1.446048	0	0	90.01
91.00	09100	EMERGENCY	234,166	16,566,023	0.014135	10,928	154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,518	1,068,645	0.073474	0	0	92.00
200.00		Total (lines 50 through 199)	1,781,278	87,157,875		3,012,229	47,912	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
54.02	03480	ONCOLOGY	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,359,447	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	396,206	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	308,516	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,905,101	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	1,144,566	0.000000	54.01
54.02	03480	ONCOLOGY	0	0	0	8,180,741	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	17,105,577	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	15,030,631	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,086,568	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,511,074	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	494,258	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	208,547	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,106,613	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	602,219	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	343,482	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,979,834	0.000000	73.00
73.01	03950	ONCOLOGY	0	0	0	0	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0	0	0	2,061,932	0.000000	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0	0	0	2,139,152	0.000000	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0	0	0	1,543,201	0.000000	88.02
90.00	09000	CLINIC	0	0	0	3,763	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	11,779	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	16,566,023	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,068,645	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	87,157,875		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	190,752	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	22,847	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	11,448	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	389,596	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	22,776	0	0	0	54.01
54.02	03480	ONCOLOGY	0.000000	279	0	0	0	54.02
57.00	05700	CT SCAN	0.000000	280,029	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	694,226	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	580,140	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	168,470	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	69,651	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	20,128	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	17,054	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	3,908	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	26,693	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	503,304	0	0	0	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000	0	0	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000	0	0	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	10,928	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,012,229	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.824498	0	810,909	0	0	50.00
51.00	05100	RECOVERY ROOM	0.631520	0	60,820	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.396456	0	54,658	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.297317	0	1,639,841	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.150373	0	313,516	0	0	54.01
54.02	03480	ONCOLOGY	0.595674	0	3,852,406	787	0	54.02
57.00	05700	CT SCAN	0.038245	0	4,421,355	27	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.232722	0	4,324,343	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.426459	0	135,570	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.279090	0	472,492	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.261171	0	78,123	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.259294	0	32,391	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188844	0	334,742	0	0	69.00
69.01	06901	CARDIAC REHAB	0.827611	0	159,455	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.727569	0	61,769	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.587672	0	521,142	56	0	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED						88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE						88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE						88.02
90.00	09000	CLINIC	2.718576	0	477	0	0	90.00
90.01	09001	RHEUMATOLOGY	35.803549	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.278937	0	3,550,798	2,300	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.855959	0	297,009	0	0	92.00
200.00		Subtotal (see instructions)		0	21,121,816	3,170	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	21,121,816	3,170	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	668,593	0		50.00
51.00	05100	RECOVERY ROOM	38,409	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	76,327	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,553	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	47,144	0		54.01
54.02	03480	ONCOLOGY	2,294,778	469		54.02
57.00	05700	CT SCAN	169,095	1		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	1,006,370	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	57,815	0		65.00
66.00	06600	PHYSICAL THERAPY	131,868	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,403	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,399	0		68.00
69.00	06900	ELECTROCARDIOLOGY	63,214	0		69.00
69.01	06901	CARDIAC REHAB	131,967	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	44,941	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,261	33		73.00
73.01	03950	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED				88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE				88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE				88.02
90.00	09000	CLINIC	1,297	0		90.00
90.01	09001	RHEUMATOLOGY	0	0		90.01
91.00	09100	EMERGENCY	990,449	642		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	254,228	0		92.00
200.00		Subtotal (see instructions)	6,799,111	1,145		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,799,111	1,145		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,685	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,506	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,872	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	165	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	14	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)	905	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)	125	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	137.42	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,855,554	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)	1,924	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)	239,981	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,615,573	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)	3,615,573	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,442.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,305,707	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,305,707	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,751,202	323	5,421.68	133	721,083	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,121,923	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,148,713	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)	180,346	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)	180,346	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)	634	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,442.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	914,716	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	330,958	3,855,554	0.085839	914,716	78,518	90.00
91.00	Nursing School cost	0	3,855,554	0.000000	914,716	0	91.00
92.00	Allied health cost	0	3,855,554	0.000000	914,716	0	92.00
93.00	All other Medical Education	0	3,855,554	0.000000	914,716	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 2:27 pm

Title XIX | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,685	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,506	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,872	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	165	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	14	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)	42	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)	165	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	137.42	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,855,554	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)	1,924	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)	239,981	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,615,573	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)	3,615,573	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,442.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	60,596	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)	60,596	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 2:27 pm

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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,751,202	323	5,421.68	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)	98,930	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	159,526	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)	238,057	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)	238,057	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)	634	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,442.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	914,716	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/15/2021 2:27 pm

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	330,958	3,855,554	0.085839	914,716	78,518	90.00
91.00	Nursing School cost	0	3,855,554	0.000000	914,716	0	91.00
92.00	Allied health cost	0	3,855,554	0.000000	914,716	0	92.00
93.00	All other Medical Education	0	3,855,554	0.000000	914,716	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,537,645		30.00
31.00	03100	INTENSIVE CARE UNIT		555,465		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.824498	190,752	157,275	50.00
51.00	05100	RECOVERY ROOM	0.631520	22,847	14,428	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.396456	11,448	15,987	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.297317	389,596	115,834	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.150373	22,776	3,425	54.01
54.02	03480	ONCOLOGY	0.595674	279	166	54.02
57.00	05700	CT SCAN	0.038245	280,029	10,710	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.232722	694,226	161,562	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.426459	580,140	247,406	65.00
66.00	06600	PHYSICAL THERAPY	0.279090	168,470	47,018	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.261171	69,651	18,191	67.00
68.00	06800	SPEECH PATHOLOGY	0.259294	20,128	5,219	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188844	17,054	3,221	69.00
69.01	06901	CARDIAC REHAB	0.827611	3,908	3,234	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.727569	26,693	19,421	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.587672	503,304	295,778	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000		0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000		0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000		0	88.02
90.00	09000	CLINIC	2.718576	0	0	90.00
90.01	09001	RHEUMATOLOGY	35.803549	0	0	90.01
91.00	09100	EMERGENCY	0.278937	10,928	3,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.855959	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,012,229	1,121,923	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)		3,012,229		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3

Component CCN: 15-Z333 | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.824498	8,496	7,005	50.00
51.00	05100	RECOVERY ROOM	0.631520	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.396456	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.297317	2,007	597	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.150373	0	0	54.01
54.02	03480	ONCOLOGY	0.595674	0	0	54.02
57.00	05700	CT SCAN	0.038245	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.232722	20,451	4,759	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.426459	14,627	6,238	65.00
66.00	06600	PHYSICAL THERAPY	0.279090	50,239	14,021	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.261171	31,731	8,287	67.00
68.00	06800	SPEECH PATHOLOGY	0.259294	5,389	1,397	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188844	2,866	541	69.00
69.01	06901	CARDIAC REHAB	0.827611	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.727569	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.587672	13,103	7,700	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	0.000000		0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	0.000000		0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	0.000000		0	88.02
90.00	09000	CLINIC	2.718576	0	0	90.00
90.01	09001	RHEUMATOLOGY	35.803549	0	0	90.01
91.00	09100	EMERGENCY	0.278937	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.855959	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		148,909	50,545	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)		148,909		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/15/2021 2:27 pm

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		17,070		30.00
31.00	03100	INTENSIVE CARE UNIT		10,478		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.824498	27,129	22,368	50.00
51.00	05100	RECOVERY ROOM	0.631520	3,236	2,044	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.396456	6,931	9,679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.297317	19,516	5,802	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.150373	542	82	54.01
54.02	03480	ONCOLOGY	0.595674	0	0	54.02
57.00	05700	CT SCAN	0.038245	35,513	1,358	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.232722	54,420	12,665	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.426459	23,372	9,967	65.00
66.00	06600	PHYSICAL THERAPY	0.279090	6,864	1,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.261171	973	254	67.00
68.00	06800	SPEECH PATHOLOGY	0.259294	288	75	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188844	1,985	375	69.00
69.01	06901	CARDIAC REHAB	0.827611	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.727569	298	217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.587672	34,856	20,484	73.00
73.01	03950	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	PUTNAM PEDIATRICS AND INTERNAL MED	1.317544	0	0	88.00
88.01	08801	FAMILY MEDICINE OF CLOVERDALE	1.086142	0	0	88.01
88.02	08802	NORTH PUTNAM FAMILY HEALTHCARE	1.522297	0	0	88.02
90.00	09000	CLINIC	2.718576	0	0	90.00
90.01	09001	RHEUMATOLOGY	35.803549	0	0	90.01
91.00	09100	EMERGENCY	0.278937	41,745	11,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.855959	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		257,668	98,930	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)		257,668		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,800,256	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)	6,800,256	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)	6,868,259	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)	68,899	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,353,977	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,445,383	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,445,383	30.00
31.00	Primary payer payments	2,673	31.00
32.00	Subtotal (line 30 minus line 31)	3,442,710	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)	674,431	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	438,380	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	551,466	36.00
37.00	Subtotal (see instructions)	3,881,090	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,881,090	40.00
40.01	Sequestration adjustment (see instructions)	25,615	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,095,091	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	760,384	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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,487,644		3,095,091	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		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)		2,487,644		3,095,091	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		358,354		760,384	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,845,998		3,855,475	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: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		195,674		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)		195,674		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		33,713		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		229,387		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: 15-1333	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/15/2021 2:27 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	182,149	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)	51,050	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	125	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)	233,199	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	233,199	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)	233,199	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,288	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	230,911	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)	230,911	0	19.00
19.01	Sequestration adjustment (see instructions)	1,524	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	195,674	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)	33,713	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: 15-1333	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/15/2021 2:27 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,148,713	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,148,713	4.00
5.00	Primary payer payments	3,236	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,176,964	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)	3,176,964	19.00
20.00	Deductibles (exclude professional component)	330,792	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,846,172	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,846,172	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,821	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,734	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,644	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,864,906	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,864,906	30.00
30.01	Sequestration adjustment (see instructions)	18,908	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,487,644	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)	358,354	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: 15-1333	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/15/2021 2:27 pm
	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	159,526		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)	159,526	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)	159,526	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	27,548		8.00
9.00	Ancillary service charges	257,668	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)	285,216	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)	285,216	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	125,690	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)	159,526	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)	159,526	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)	159,526	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)	159,526	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	159,526	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)	159,526	0	40.00
41.00	Interim payments	134,758	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	24,768	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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/15/2021 2:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	13,998,806	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	3,909,170	0	0	0	4.00
5.00	Other receivable	3,212,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,215,319	0	0	0	6.00
7.00	Inventory	873,674	0	0	0	7.00
8.00	Prepaid expenses	508,270	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)	17,286,601	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	195,501	0	0	0	12.00
13.00	Land improvements	391,896	0	0	0	13.00
14.00	Accumulated depreciation	-273,908	0	0	0	14.00
15.00	Buildings	35,564,661	0	0	0	15.00
16.00	Accumulated depreciation	-24,407,684	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,908,511	0	0	0	23.00
24.00	Accumulated depreciation	-21,511,346	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,867,631	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,525,373	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	244,800	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,770,173	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,924,405	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,727,986	0	0	0	37.00
38.00	Salaries, wages, and fees payable	142,663	0	0	0	38.00
39.00	Payroll taxes payable	257,758	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,014,902	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,889,981	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,033,290	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,562,759	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)	5,562,759	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,596,049	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,328,356				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)	18,328,356	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,924,405	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/15/2021 2:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		27,138,332		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,809,976				2.00
3.00	Total (sum of line 1 and line 2)		18,328,356		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)		18,328,356		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)		18,328,356		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: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/15/2021 2:27 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,388,076		4,388,076	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,388,076		4,388,076	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,448,320		1,448,320	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)	1,448,320		1,448,320	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,836,396		5,836,396	17.00
18.00	Ancillary services	7,030,016	56,733,868	63,763,884	18.00
19.00	Outpatient services	445,942	22,815,844	23,261,786	19.00
20.00	PUTNAM PEDIATRICS AND INTERNAL MED	0	2,061,932	2,061,932	20.00
20.01	FAMILY MEDICINE OF CLOVERDALE	0	2,139,152	2,139,152	20.01
20.02	NORTH PUTNAM FAMILY HEALTHCARE	0	1,543,201	1,543,201	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	125,886	4,701,976	4,827,862	27.00
27.01	JOHNSON NICHOLS / WIC	0	380,858	380,858	27.01
27.02	RHEUMATOLOGY	0	0	0	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,438,240	90,376,831	103,815,071	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,887,342		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)		51,887,342		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/15/2021 2:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	103,815,071	1.00
2.00	Less contractual allowances and discounts on patients' accounts	68,836,945	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,978,126	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,887,342	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-16,909,216	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING AND NON-OPERATING IN	2,904,601	24.00
24.50	COVID-19 PHE Funding	5,194,639	24.50
25.00	Total other income (sum of lines 6-24)	8,099,240	25.00
26.00	Total (line 5 plus line 25)	-8,809,976	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)	-8,809,976	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/15/2021 2:27 pm

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	557,955	0	557,955	0	557,955	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	276,577	0	276,577	0	276,577	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	104,684	0	104,684	0	104,684	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)	939,216	0	939,216	0	939,216	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	939,216	0	939,216	0	939,216	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	31,409	600	32,009	0	32,009	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)	31,409	600	32,009	0	32,009	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	463,111	342,079	805,190	-96,246	708,944	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	463,111	342,079	805,190	-96,246	708,944	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,433,736	342,679	1,776,415	-96,246	1,680,169	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/15/2021 2:27 pm

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	557,955		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	276,577		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	104,684		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	939,216		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	939,216		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	32,009		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	32,009		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-255	708,689		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-255	708,689		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-255	1,679,914		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/15/2021 2:27 pm

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	281,196	0	281,196	0	281,196	1.00
2.00	Physician Assistant	446,465	0	446,465	0	446,465	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	727,661	0	727,661	0	727,661	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	727,661	0	727,661	0	727,661	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	24,093	600	24,693	0	24,693	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)	24,093	600	24,693	0	24,693	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	417,264	394,959	812,223	-96,651	715,572	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	417,264	394,959	812,223	-96,651	715,572	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,169,018	395,559	1,564,577	-96,651	1,467,926	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/15/2021 2:27 pm

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	281,196		1.00
2.00	Physician Assistant	0	446,465		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	727,661		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	727,661		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	24,693		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	24,693		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-75,000	640,572		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-75,000	640,572		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-75,000	1,392,926		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/15/2021 2:27 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	334,727	0	334,727	0	334,727	1.00
2.00	Physician Assistant	116,544	0	116,544	0	116,544	2.00
3.00	Nurse Practitioner	285,835	0	285,835	0	285,835	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	737,106	0	737,106	0	737,106	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	737,106	0	737,106	0	737,106	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	11,722	600	12,322	0	12,322	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)	11,722	600	12,322	0	12,322	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	407,466	366,715	774,181	-85,963	688,218	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	407,466	366,715	774,181	-85,963	688,218	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,156,294	367,315	1,523,609	-85,963	1,437,646	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-1 | Date/Time Prepared: 7/15/2021 2:27 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	334,727		1.00
2.00	Physician Assistant	0	116,544		2.00
3.00	Nurse Practitioner	0	285,835		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	737,106		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	737,106		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	12,322		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	12,322		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-19,992	668,226		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-19,992	668,226		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-19,992	1,417,654		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 7/15/2021 2:27 pm

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	1.68	3,919	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	2.47	4,644	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.15	8,563		4	8,563	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.90	1,132			1,132	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)	5.05	9,695			9,695	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)					939,216	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					32,009	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					971,225	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.967043	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					708,689	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,036,772	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,745,461	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,745,461	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,687,936	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,627,152	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 7/15/2021 2:27 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.94	1,832	1	1		1.00
2.00	Physician Assistant	3.39	7,876	1	3		2.00
3.00	Nurse Practitioner	0.05	113	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.38	9,821		4	9,821	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.38	9,821			9,821	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)					727,661	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					24,693	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					752,354	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.967179	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					640,572	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					930,497	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,571,069	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,571,069	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,519,505	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,247,166	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-2 | Date/Time Prepared: 7/15/2021 2:27 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.62	2,853	1	2		1.00
2.00	Physician Assistant	0.90	1,893	1	1		2.00
3.00	Nurse Practitioner	1.75	3,056	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.27	7,802		5	7,802	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.27	7,802			7,802	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)					737,106	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					12,322	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					749,428	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.983558	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					668,226	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					931,556	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,599,782	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,599,782	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,573,478	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,310,584	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1333 Component CCN: 15-8515	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/15/2021 2:27 pm
	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)			2,627,152	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			145,526	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,481,626	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,695	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)			9,695	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			255.97	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	86.31		8.00
9.00	Rate for Program covered visits (see instructions)	255.97	255.97		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	878		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	224,742		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	41		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	10,495		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	10,495		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	235,237		16.00
16.01	Total program charges (see instructions)(from contractor's records)		181,760		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,860		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,232		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.)		158,681		16.04
16.05	Total program cost (see instructions)	0	177,913		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,654		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		29,593		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		177,913		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,390		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		189,303		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)		189,303		26.00
26.01	Sequestration adjustment (see instructions)		1,249		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		118,925		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)		69,129		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: 15-1333 Component CCN: 15-8513	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/15/2021 2:27 pm
	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)			2,247,166	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			165,196	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,081,970	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,821	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)			9,821	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			211.99	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	86.31		8.00
9.00	Rate for Program covered visits (see instructions)	211.99	211.99		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,258		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	266,683		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	266,683		16.00
16.01	Total program charges (see instructions)(from contractor's records)		252,543		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,410		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,601		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.)		177,038		16.04
16.05	Total program cost (see instructions)	0	180,639		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		41,784		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		41,457		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		180,639		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		21,654		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		202,293		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)		202,293		26.00
26.01	Sequestration adjustment (see instructions)		1,335		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		149,759		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)		51,199		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: 15-1333 Component CCN: 15-8514	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3 Date/Time Prepared: 7/15/2021 2:27 pm
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,310,584	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			100,358	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,210,226	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,802	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)			7,802	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			283.29	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	86.31		8.00
9.00	Rate for Program covered visits (see instructions)	283.29	283.29		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,242		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	351,846		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	48		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	13,598		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	13,598		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	365,444		16.00
16.01	Total program charges (see instructions)(from contractor's records)		228,884		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,145		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,391		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.)		258,208		16.04
16.05	Total program cost (see instructions)	0	277,599		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		23,293		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		38,571		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		277,599		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,762		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		290,361		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)		290,361		26.00
26.01	Sequestration adjustment (see instructions)		1,916		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		196,302		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)		92,143		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: 15-1333 Component CCN: 15-8515	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 7/15/2021 2:27 pm
	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)	939,216	939,216	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001239	0.005652	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,164	5,308	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	28,617	16,937	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	29,781	22,245	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	939,216	939,216	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,687,936	1,687,936	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.031708	0.023685	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	53,521	39,979	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	83,302	62,224	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	157	716	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	530.59	86.91	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	70	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,306	6,084	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)		145,526	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)		11,390	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-4 | Date/Time Prepared: 7/15/2021 2:27 pm

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)	727,661	727,661	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001194	0.007018	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	869	5,107	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	21,729	25,787	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	22,598	30,894	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	727,661	727,661	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,519,505	1,519,505	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.031056	0.042457	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	47,190	64,514	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	69,788	95,408	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	147	864	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	474.75	110.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	166	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,323	18,331	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)		165,196	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)		21,654	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-4 | Date/Time Prepared: 7/15/2021 2:27 pm

Title XVIII | RHC III | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	737,106	737,106	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000834	0.004430	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	615	3,265	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	14,403	13,733	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	15,018	16,998	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	737,106	737,106	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,573,478	1,573,478	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.020374	0.023060	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	32,058	36,284	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	47,076	53,282	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	96	510	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	490.38	104.47	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	94	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,942	9,820	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)		100,358	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		12,762	16.00

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

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2020 To 12/31/2020 | Worksheet M-5 | Date/Time Prepared: 7/15/2021 2:27 pm

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		118,925	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)		118,925	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		69,129	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		188,054	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: 15-1333 Component CCN: 15-8513	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/15/2021 2:27 pm

			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			114,359	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			11/30/2020	35,400	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)			35,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			149,759	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			51,199	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			200,958	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: 15-1333 Component CCN: 15-8514	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 7/15/2021 2:27 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		196,302	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)		196,302	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		92,143	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		288,445	7.00

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