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: 15-1311	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/9/2021 10:17 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/9/2021 Time: 10:17 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH TIPTON HOSPITAL (15-1311) 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) CARA BREIDSTER
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	867,498	-956,263	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	148,383	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1,015,881	-956,263	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 10:17 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: TIPTON	State: IN	Zip Code: 46072	County: TIPTON	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	IU HEALTH TIPTON HOSPITAL	151311	99915	1	11/12/2005	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	IU HEALTH TIPTON HOSPITAL	15Z311	29020		11/12/2005	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									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)	2		21.00

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 10:17 am

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

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

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 10:17 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 10:17 am

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

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

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

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

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		1.00	2.00	3.00	
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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	48,121	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/9/2021 10:17 am

		1.00	2.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1311	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/9/2021 10:17 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	17	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/9/2021 10:17 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/25/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/02/2021	Y	04/02/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/9/2021 10:17 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1311	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/9/2021 10:17 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF GOVERNMENT PROGRAMS		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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/9/2021 10:17 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	46,512.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	46,512.00	0	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)		25	9,150	46,512.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/9/2021 10:17 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,146	4	1,938			1.00
2.00	HMO and other (see instructions)	458	115				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	224	0	224			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	36			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,370	4	2,198			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)	1,370	4	2,198	0.00	170.17	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
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	170.17	27.00
28.00	Observation Bed Days		0	390			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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/9/2021 10:17 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	322	2	545	1.00
2.00	HMO and other (see instructions)			110	28		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	322	2	545	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-10 | Date/Time Prepared: 7/9/2021 10:17 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.319824	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,779,344	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	18,345,822	6.00
7.00	Medicaid cost (line 1 times line 6)	5,867,434	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)	3,088,090	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)	830	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	4,442	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	1,421	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)	591	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)	3,088,681	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)	876,150	58,533	934,683	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	280,214	58,533	338,747	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)	280,214	58,533	338,747	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,481,510	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	171,520	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	263,877	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,217,633	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	481,785	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	820,532	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,909,213	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	766,963	766,963	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES		0	0	658,849	658,849	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	935,043	935,043	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	241,702	19,759	261,461	2,076,372	2,337,833	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	951,818	10,318,279	11,270,097	-2,473,498	8,796,599	5.00
7.00	00700	OPERATION OF PLANT	891,983	3,516,184	4,408,167	-24,375	4,383,792	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	50,172	50,172	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	59,571	85,157	144,728	-26,972	117,756	8.00
9.00	00900	HOUSEKEEPING	351,341	263,886	615,227	-151,369	463,858	9.00
10.00	01000	DIETARY	385,073	545,002	930,075	-709,394	220,681	10.00
11.00	01100	CAFETERIA	0	0	0	597,274	597,274	11.00
13.00	01300	NURSING ADMINISTRATION	623,639	181,108	804,747	82,190	886,937	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,792	1,792	705,782	707,574	14.00
15.00	01500	PHARMACY	711,978	5,667,792	6,379,770	-5,209,088	1,170,682	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,882,063	1,270,715	3,152,778	-501,571	2,651,207	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,010,847	2,671,077	3,681,924	-2,198,940	1,482,984	50.00
53.00	05300	ANESTHESIOLOGY	179,716	334,239	513,955	-23,084	490,871	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,072,407	549,203	1,621,610	-268,188	1,353,422	54.00
60.00	06000	LABORATORY	0	1,411,862	1,411,862	0	1,411,862	60.00
65.00	06500	RESPIRATORY THERAPY	533,410	200,525	733,935	-155,666	578,269	65.00
66.00	06600	PHYSICAL THERAPY	743,285	417,466	1,160,751	-391,877	768,874	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,853	47,940	231,793	20,073	251,866	67.00
68.00	06800	SPEECH PATHOLOGY	22,851	3,701	26,552	1,089	27,641	68.00
69.00	06900	ELECTROCARDIOLOGY	504,218	231,500	735,718	-77,462	658,256	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	409,034	409,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,200,134	1,200,134	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,996,998	3,996,998	73.00
73.01	03480	ONCOLOGY	216,393	87,461	303,854	-50,469	253,385	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	1,197,921	1,197,921	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	79,584	21,505	101,089	-16,718	84,371	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,063,963	1,999,794	3,063,757	-312,414	2,751,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,709,695	29,845,947	41,555,642	106,809	41,662,451	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	104,443	93,554	197,997	-80,988	117,009	192.00
192.01	19201	OCCUPATIONAL MEDICINE	53,385	83,755	137,140	-25,821	111,319	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	11,867,523	30,023,256	41,890,779	0	41,890,779	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	792,494	1,559,457		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	-550,676	108,173		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	279,710	1,214,753		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	228,856	2,566,689		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-728,141	8,068,458		5.00
7.00	00700	OPERATION OF PLANT	-21,881	4,361,911		7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	-50,172	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	117,756		8.00
9.00	00900	HOUSEKEEPING	-61,338	402,520		9.00
10.00	01000	DIETARY	130	220,811		10.00
11.00	01100	CAFETERIA	-136,636	460,638		11.00
13.00	01300	NURSING ADMINISTRATION	19,500	906,437		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	707,574		14.00
15.00	01500	PHARMACY	-336,443	834,239		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-595,089	2,056,118		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-265,956	1,217,028		50.00
53.00	05300	ANESTHESIOLOGY	-431,452	59,419		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-133,820	1,219,602		54.00
60.00	06000	LABORATORY	0	1,411,862		60.00
65.00	06500	RESPIRATORY THERAPY	0	578,269		65.00
66.00	06600	PHYSICAL THERAPY	0	768,874		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	251,866		67.00
68.00	06800	SPEECH PATHOLOGY	0	27,641		68.00
69.00	06900	ELECTROCARDIOLOGY	-121,406	536,850		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	409,034		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,200,134		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,996,998		73.00
73.01	03480	ONCOLOGY	0	253,385		73.01
73.02	07301	BLOOD DISORDER DRUGS	0	1,197,921		73.02
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	84,371		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,055,642	1,695,701		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,167,962	38,494,489		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	117,009		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	111,319		192.01
192.02	19202	VACANT SPACE	0	0		192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,167,962	38,722,817		200.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/9/2021 10:17 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	553,461	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	933,043	2.00
	0		0	1,486,504	
	B - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	658,849	1.00
2.00		0.00	0	0	2.00
	0		0	658,849	
	C - OTHER CAPITAL				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,032	1.00
	0		0	5,032	
	D - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,076,349	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	2,076,349	
	E - CAFETERIA				
1.00	CAFETERIA	11.00	281,182	316,092	1.00
	0		281,182	316,092	
	F - MEDICAL SUPPLIES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23	1.00
2.00	OPERATION OF PLANT	7.00	0	31,227	2.00
3.00	NURSING ADMINISTRATION	13.00	0	2,924	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	705,782	4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	409,034	5.00
6.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,200,134	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	2,349,124	
	G - DRUGS				
1.00	PHARMACY	15.00	0	45,967	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,194,919	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	5,240,886	

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/9/2021 10:17 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - ORTHOPEDIC CLERICAL STAFF				
1.00	OCCUPATIONAL THERAPY	67.00	53,465	0	1.00
2.00	SPEECH PATHOLOGY	68.00	2,027	0	2.00
	0		55,492	0	
	I - VP OF NURSING				
1.00	NURSING ADMINISTRATION	13.00	178,606	0	1.00
	0		178,606	0	
	J - MAINTENANCE & LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	166,567	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,348	2.00
3.00	OPERATION OF PLANT	7.00	0	6,199	3.00
4.00	OPERATION OF PLANT - OFFSITE	7.01	0	50,172	4.00
	0		0	224,286	
	L - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,967	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,000	2.00
	0		0	53,967	
	M - INFUSION DRUGS				
1.00	BLOOD DISORDER DRUGS	73.02	0	1,197,921	1.00
	TOTALS		0	1,197,921	
500.00	Grand Total: Increases		515,280	13,609,010	500.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/9/2021 10:17 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,477,569	9		1.00
2.00	OPERATION OF PLANT	7.00	0	8,935	9		2.00
	0		0	1,486,504			
	B - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	657,308	11		1.00
2.00	OPERATION OF PLANT	7.00	0	1,541	0		2.00
	0		0	658,849			
	C - OTHER CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,032	13		1.00
	0		0	5,032			
	D - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	102,021	0		1.00
2.00	OPERATION OF PLANT	7.00	0	51,325	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	26,972	0		3.00
4.00	HOUSEKEEPING	9.00	0	133,088	0		4.00
5.00	DIETARY	10.00	0	112,097	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	99,340	0		6.00
7.00	PHARMACY	15.00	0	104,435	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	388,689	0		8.00
9.00	OPERATING ROOM	50.00	0	198,032	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	7,591	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	204,276	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	119,504	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	143,311	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	32,779	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	915	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	54,804	0		16.00
17.00	ONCOLOGY	73.01	0	34,377	0		17.00
18.00	CARDIAC REHABILITATION	76.97	0	15,879	0		18.00
19.00	EMERGENCY	91.00	0	203,019	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	29,515	0		20.00
21.00	OCCUPATIONAL MEDICINE	192.01	0	14,380	0		21.00
	0		0	2,076,349			
	E - CAFETERIA						
1.00	DIETARY	10.00	281,182	316,092	0		1.00
	0		281,182	316,092			
	F - MEDICAL SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,330	0		1.00
2.00	HOUSEKEEPING	9.00	0	18,281	0		2.00
3.00	DIETARY	10.00	0	23	0		3.00
4.00	PHARMACY	15.00	0	33,536	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	105,864	0		5.00
6.00	OPERATING ROOM	50.00	0	1,989,782	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,929	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	35,927	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	19,163	0		9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	613	0		10.00
11.00	SPEECH PATHOLOGY	68.00	0	23	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	8,663	0		12.00
13.00	ONCOLOGY	73.01	0	13,279	0		13.00
14.00	CARDIAC REHABILITATION	76.97	0	830	0		14.00
15.00	EMERGENCY	91.00	0	92,305	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	848	0		16.00
17.00	OCCUPATIONAL MEDICINE	192.01	0	1,728	0		17.00
	0		0	2,349,124			
	G - DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	77	0		1.00
2.00	PHARMACY	15.00	0	5,117,084	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	7,018	0		3.00
4.00	OPERATING ROOM	50.00	0	11,126	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	15,493	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	45,983	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	235	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	250	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	13,995	0		9.00
10.00	ONCOLOGY	73.01	0	2,813	0		10.00
11.00	CARDIAC REHABILITATION	76.97	0	9	0		11.00
12.00	EMERGENCY	91.00	0	17,090	0		12.00
13.00	OCCUPATIONAL MEDICINE	192.01	0	9,713	0		13.00
	0		0	5,240,886			

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/9/2021 10:17 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSICAL THERAPY	66.00	55,492	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		55,492	0			
	I - VP OF NURSING						
1.00	ADMINISTRATIVE & GENERAL	5.00	178,606	0	0		1.00
	0		178,606	0			
	J - MAINTENANCE & LEASE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	173,661	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	50,625	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	224,286			
	L - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	53,967	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	53,967			
	M - INFUSION DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,197,921	0		1.00
	TOTALS		0	1,197,921			
500.00	Grand Total: Decreases		515,280	13,609,010			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/9/2021 10:17 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,872,457	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,249,840	719,748	0	719,748	1,629,180	6.00
7.00	HIT designated Assets	964,363	-123,712	0	-123,712	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,086,660	596,036	0	596,036	1,629,180	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,086,660	596,036	0	596,036	1,629,180	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	2,872,457	372,370	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,340,408	7,154,001	6.00
7.00	HIT designated Assets	840,651	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,053,516	7,526,371	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	15,053,516	7,526,371	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II Date/Time Prepared: 7/9/2021 10:17 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	0		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III | Date/Time Prepared: 7/9/2021 10:17 am

	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	CAP REL COSTS-BLDG & FIXT	3,713,108	0	3,713,108	0.246661	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	11,340,407	0	11,340,407	0.753339	0	2.00
3.00	Total (sum of lines 1-2)	15,053,515	0	15,053,515	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1,376,531	135,991	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	364,711	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,212,753	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,953,995	135,991	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	51,967	-5,032	0	1,559,457	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	-256,538	0	0	0	108,173	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,000	0	0	1,214,753	2.00
3.00	Total (sum of lines 1-2)	-256,538	53,967	-5,032	0	2,882,383	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/9/2021 10:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	B	-915,387	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	11	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	-2,455,450			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	3,618,214			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-136,636	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	B	-336,439	PHARMACY	15.00	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 - CAP REL COSTS-BLDG & FIXT	A	781,648	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - INTERES		0	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	35,545	CAP REL COSTS-MVBLE EQUIP	2.00	9	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/9/2021 10:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-45,472	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	INVESTMENT FEES	A	7,362	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-61,338	HOUSEKEEPING	9.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	130	DIETARY	10.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-19,542	ELECTROCARDIOLOGY	69.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-4	PHARMACY	15.00	0	33.05
33.06	MEDICAID HOSPITAL ASSESSMENT FEE	B	-1,161,849	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	ASSISTED LIVING DEPRECIATION - BLDG	A	-125,780	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	ASSISTED LIVING DEPRECIATION - MVBLE	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	CRNA SALARY EXPENSE	A	-179,716	ANESTHESIOLOGY	53.00	0	33.09
33.10	CRNA BENEFITS EXPENSE	A	-40,565	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	PATIENT PHONES - SALARY	A	-2,719	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PATIENT PHONES - BENEFITS	A	-614	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	EMPLOYEE BENEFITS	A	-2,076,349	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	CABLE	A	-326	OPERATION OF PLANT	7.00	0	33.14
33.15	LEASE REVENUE	B	-30,576	CAP REL COSTS-BLDG & FIXT	1.00	10	33.15
33.16	ACCRUED PTO	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	LEASE DEPRECIATION - CARRY FORWARD A	A	284	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	EQUIPMENT DEPRECIATION - CARRY FORWA	A	22,433	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.18
33.19	RECRUTING	A	-18,571	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	MARKETING	A	-26,245	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	MARKETING	A	0	PHYSICAL THERAPY	66.00	0	33.21
33.22	MARKETING	A	0	EMERGENCY	91.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,167,962				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/9/2021 10:17 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	289,059	122,141	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	1,022,019	657,308	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	221,732	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	2,350,752	4,368	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	6,674,728	6,120,212	4.01
4.02	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	685,782	707,337	4.02
4.03	7.01	OPERATION OF PLANT - OFFSITE	HOME OFFICE ALLOCATION	0	50,172	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	13.00	NURSING ADMINISTRATION	RELATED PARTY EXPENSE	56,076	36,576	4.06
4.07	30.00	ADULTS & PEDIATRICS	RELATED PARTY EXPENSE	584,586	584,586	4.07
4.08	50.00	OPERATING ROOM	RELATED PARTY EXPENSE	31,100	31,100	4.08
4.09	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY EXPENSE	175,473	159,293	4.09
4.10	60.00	LABORATORY	RELATED PARTY EXPENSE	1,387,823	1,387,823	4.10
4.11	69.00	ELECTROCARDIOLOGY	RELATED PARTY EXPENSE	293,939	293,939	4.11
4.12	73.01	ONCOLOGY	RELATED PARTY EXPENSE	5,826	5,826	4.12
4.13	91.00	EMERGENCY	RELATED PARTY EXPENSE	1,616,232	1,616,232	4.13
4.14	192.01	OCCUPATIONAL MEDICINE	RELATED PARTY EXPENSE	32,844	32,844	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,427,971	11,809,757	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/9/2021 10:17 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	166,918	9		1.00
2.00	364,711	9		2.00
3.00	221,732	9		3.00
4.00	2,346,384	0		4.00
4.01	554,516	0		4.01
4.02	-21,555	0		4.02
4.03	-50,172	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	19,500	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	16,180	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
5.00	3,618,214			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-2 | Date/Time Prepared: 7/9/2021 10:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	53,734	53,734	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	576,518	576,518	0	0	0	2.00
3.00	50.00	OPERATING ROOM	265,956	265,956	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	251,736	251,736	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	150,000	150,000	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	101,864	101,864	0	0	0	6.00
7.00	91.00	EMERGENCY	1,595,233	1,055,642	539,591	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,995,041	2,455,450	539,591		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	53,734		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	576,518		2.00
3.00	50.00	OPERATING ROOM	0	0	0	265,956		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	251,736		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	150,000		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	101,864		6.00
7.00	91.00	EMERGENCY	0	0	0	1,055,642		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	2,455,450		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,559,457	1,559,457				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	108,173	0	108,173			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,214,753			1,214,753		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,566,689	6,910	547	5,256	2,579,402	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,068,458	98,019	7,760	74,553	173,673	5.00
7.00	00700	OPERATION OF PLANT	4,361,911	375,273	26,067	285,429	201,057	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	117,756	25,490	2,018	19,388	13,428	8.00
9.00	00900	HOUSEKEEPING	402,520	15,209	1,204	11,568	79,194	9.00
10.00	01000	DIETARY	220,811	17,985	1,424	13,680	23,418	10.00
11.00	01100	CAFETERIA	460,638	48,672	3,853	37,020	63,380	11.00
13.00	01300	NURSING ADMINISTRATION	906,437	34,804	2,755	26,472	180,830	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	707,574	32,988	2,612	25,090	0	14.00
15.00	01500	PHARMACY	834,239	18,112	1,434	13,776	160,483	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,056,118	151,293	11,977	143,711	424,231	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,217,028	192,365	15,229	146,312	227,850	50.00
53.00	05300	ANESTHESIOLOGY	59,419	3,626	287	2,758	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,219,602	100,613	7,965	76,526	241,726	54.00
60.00	06000	LABORATORY	1,411,862	39,311	3,112	29,900	0	60.00
65.00	06500	RESPIRATORY THERAPY	578,269	2,380	188	1,810	120,233	65.00
66.00	06600	PHYSICAL THERAPY	768,874	55,527	1,580	42,233	155,032	66.00
67.00	06700	OCCUPATIONAL THERAPY	251,866	18,390	523	13,987	53,493	67.00
68.00	06800	SPEECH PATHOLOGY	27,641	698	20	531	5,608	68.00
69.00	06900	ELECTROCARDIOLOGY	536,850	26,157	2,071	19,895	113,653	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	409,034	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,200,134	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,996,998	0	0	0	0	73.00
73.01	03480	ONCOLOGY	253,385	15,764	1,248	11,990	48,776	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,197,921	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	84,371	17,160	1,359	13,052	17,939	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,695,701	111,379	8,818	84,714	239,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,494,489	1,408,125	104,051	1,099,651	2,543,827	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	117,009	136,917	2,981	104,138	23,542	192.00
192.01	19201	OCCUPATIONAL MEDICINE	111,319	14,415	1,141	10,964	12,033	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,722,817	1,559,457	108,173	1,214,753	2,579,402	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,422,463	8,422,463				5.00
7.00	00700	OPERATION OF PLANT	5,249,737	1,459,243	6,708,980			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	178,080	49,500	174,076	0	401,656	8.00
9.00	00900	HOUSEKEEPING	509,695	141,678	103,860	0	0	9.00
10.00	01000	DIETARY	277,318	77,085	122,823	0	0	10.00
11.00	01100	CAFETERIA	613,563	170,550	332,385	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,151,298	320,022	237,681	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	768,264	213,551	225,274	0	0	14.00
15.00	01500	PHARMACY	1,028,044	285,761	123,690	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,787,330	774,783	1,033,184	0	401,656	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,798,784	500,001	1,313,665	0	0	50.00
53.00	05300	ANESTHESIOLOGY	66,090	18,371	24,760	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,646,432	457,652	687,092	0	0	54.00
60.00	06000	LABORATORY	1,484,185	412,553	268,455	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	702,880	195,377	16,254	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,023,246	284,428	136,259	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	338,259	94,025	45,131	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	34,498	9,589	1,734	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	698,626	194,194	178,627	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	409,034	113,698	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,200,134	333,596	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,996,998	1,111,030	0	0	0	73.00
73.01	03480	ONCOLOGY	331,163	92,052	107,653	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,197,921	332,981	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	133,881	37,214	117,188	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,140,435	594,968	760,612	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,188,358	8,273,902	6,010,403	0	401,656	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	384,587	106,902	600,135	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	149,872	41,659	98,442	0	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	38,722,817	8,422,463	6,708,980	0	401,656	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	755,233					9.00
10.00	01000	DIETARY	13,079	490,305				10.00
11.00	01100	CAFETERIA	35,394	0	1,151,892			11.00
13.00	01300	NURSING ADMINISTRATION	25,310	0	68,098	1,802,409		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,988	0	0	0	1,231,077	14.00
15.00	01500	PHARMACY	13,171	0	69,374	0	17,800	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,019	490,305	267,378	786,586	43,780	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,887	0	123,529	383,534	237,642	50.00
53.00	05300	ANESTHESIOLOGY	2,637	0	8,502	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,165	0	128,630	0	9,548	54.00
60.00	06000	LABORATORY	28,587	0	83,401	0	12,349	60.00
65.00	06500	RESPIRATORY THERAPY	1,731	0	56,196	0	18,584	65.00
66.00	06600	PHYSICAL THERAPY	40,379	0	73,710	0	6,803	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,373	0	27,715	0	319	67.00
68.00	06800	SPEECH PATHOLOGY	508	0	2,465	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	19,021	0	50,500	134,165	4,777	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	210,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	616,737	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	11,463	0	25,165	52,671	6,853	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	12,479	0	8,757	39,763	509	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	80,994	0	135,262	362,101	43,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	645,185	490,305	1,128,682	1,758,820	1,229,896	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	99,565	0	13,603	0	250	192.00
192.01	19201	OCCUPATIONAL MEDICINE	10,483	0	9,607	43,589	931	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	755,233	490,305	1,151,892	1,802,409	1,231,077	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,537,840					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,059	6,697,080	0	6,697,080		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,078	4,500,120	0	4,500,120		50.00
53.00	05300	ANESTHESIOLOGY	0	120,360	0	120,360		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	462	3,002,981	0	3,002,981		54.00
60.00	06000	LABORATORY	0	2,289,530	0	2,289,530		60.00
65.00	06500	RESPIRATORY THERAPY	69	991,091	0	991,091		65.00
66.00	06600	PHYSICAL THERAPY	69	1,564,894	0	1,564,894		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	518,822	0	518,822		67.00
68.00	06800	SPEECH PATHOLOGY	0	48,806	0	48,806		68.00
69.00	06900	ELECTROCARDIOLOGY	50	1,279,960	0	1,279,960		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	732,930	0	732,930		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,150,467	0	2,150,467		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,172,861	6,280,889	0	6,280,889		73.00
73.01	03480	ONCOLOGY	813	627,833	0	627,833		73.01
73.02	07301	BLOOD DISORDER DRUGS	351,513	1,882,415	0	1,882,415		73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	3	349,794	0	349,794		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,015	4,123,372	0	4,123,372		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,535,992	37,161,344	0	37,161,344		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,205,042	0	1,205,042		192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,848	356,431	0	356,431		192.01
192.02	19202	VACANT SPACE	0	0	0	0		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,537,840	38,722,817	0	38,722,817		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,910	547	5,256	12,713	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	98,019	7,760	74,553	180,332	5.00
7.00	00700	OPERATION OF PLANT	0	375,273	26,067	285,429	686,769	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,490	2,018	19,388	46,896	8.00
9.00	00900	HOUSEKEEPING	0	15,209	1,204	11,568	27,981	9.00
10.00	01000	DIETARY	0	17,985	1,424	13,680	33,089	10.00
11.00	01100	CAFETERIA	0	48,672	3,853	37,020	89,545	11.00
13.00	01300	NURSING ADMINISTRATION	0	34,804	2,755	26,472	64,031	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,988	2,612	25,090	60,690	14.00
15.00	01500	PHARMACY	0	18,112	1,434	13,776	33,322	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	151,293	11,977	143,711	306,981	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	192,365	15,229	146,312	353,906	50.00
53.00	05300	ANESTHESIOLOGY	0	3,626	287	2,758	6,671	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,613	7,965	76,526	185,104	54.00
60.00	06000	LABORATORY	0	39,311	3,112	29,900	72,323	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,380	188	1,810	4,378	65.00
66.00	06600	PHYSICAL THERAPY	0	55,527	1,580	42,233	99,340	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,390	523	13,987	32,900	67.00
68.00	06800	SPEECH PATHOLOGY	0	698	20	531	1,249	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,157	2,071	19,895	48,123	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	15,764	1,248	11,990	29,002	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	17,160	1,359	13,052	31,571	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	111,379	8,818	84,714	204,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,408,125	104,051	1,099,651	2,611,827	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	136,917	2,981	104,138	244,036	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	14,415	1,141	10,964	26,520	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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	1,559,457	108,173	1,214,753	2,882,383	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4.00	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,713					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	856	181,188				5.00
7.00	00700	OPERATION OF PLANT	991	31,385	719,145			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	66	1,065	18,659	0	66,686	8.00
9.00	00900	HOUSEKEEPING	390	3,048	11,133	0	0	9.00
10.00	01000	DIETARY	115	1,658	13,166	0	0	10.00
11.00	01100	CAFETERIA	312	3,669	35,629	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	891	6,885	25,477	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,594	24,147	0	0	14.00
15.00	01500	PHARMACY	791	6,148	13,258	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,093	16,668	110,748	0	66,686	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,123	10,757	140,816	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	395	2,654	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,191	9,846	73,650	0	0	54.00
60.00	06000	LABORATORY	0	8,875	28,776	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	593	4,203	1,742	0	0	65.00
66.00	06600	PHYSICAL THERAPY	764	6,119	14,606	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	264	2,023	4,838	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	28	206	186	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	560	4,178	19,147	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,446	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,177	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,902	0	0	0	73.00
73.01	03480	ONCOLOGY	240	1,980	11,539	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	7,164	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	88	801	12,562	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,182	12,800	81,531	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,538	177,992	644,264	0	66,686	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116	2,300	64,329	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	59	896	10,552	0	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	12,713	181,188	719,145	0	66,686	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	42,552					9.00
10.00	01000	DIETARY	737	48,765				10.00
11.00	01100	CAFETERIA	1,994	0	131,149			11.00
13.00	01300	NURSING ADMINISTRATION	1,426	0	7,753	106,463		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,352	0	0	0	90,783	14.00
15.00	01500	PHARMACY	742	0	7,899	0	1,313	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,199	48,765	30,442	46,461	3,228	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,880	0	14,064	22,654	17,525	50.00
53.00	05300	ANESTHESIOLOGY	149	0	968	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,122	0	14,645	0	704	54.00
60.00	06000	LABORATORY	1,611	0	9,496	0	911	60.00
65.00	06500	RESPIRATORY THERAPY	98	0	6,398	0	1,370	65.00
66.00	06600	PHYSICAL THERAPY	2,275	0	8,392	0	502	66.00
67.00	06700	OCCUPATIONAL THERAPY	753	0	3,156	0	24	67.00
68.00	06800	SPEECH PATHOLOGY	29	0	281	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	1,072	0	5,750	7,925	352	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	15,501	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	45,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	646	0	2,865	3,111	505	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	703	0	997	2,349	38	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,563	0	15,400	21,388	3,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,351	48,765	128,506	103,888	90,696	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,610	0	1,549	0	18	192.00
192.01	19201	OCCUPATIONAL MEDICINE	591	0	1,094	2,575	69	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	42,552	48,765	131,149	106,463	90,783	202.00

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		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	63,473					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85	638,356	0	638,356		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	127	568,852	0	568,852		50.00
53.00	05300	ANESTHESIOLOGY	0	10,837	0	10,837		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19	289,281	0	289,281		54.00
60.00	06000	LABORATORY	0	121,992	0	121,992		60.00
65.00	06500	RESPIRATORY THERAPY	3	18,785	0	18,785		65.00
66.00	06600	PHYSICAL THERAPY	3	132,001	0	132,001		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	43,958	0	43,958		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,980	0	1,980		68.00
69.00	06900	ELECTROCARDIOLOGY	2	87,109	0	87,109		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,947	0	17,947		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,655	0	52,655		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,409	72,311	0	72,311		73.00
73.01	03480	ONCOLOGY	34	49,922	0	49,922		73.01
73.02	07301	BLOOD DISORDER DRUGS	14,508	21,672	0	21,672		73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	49,109	0	49,109		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	207	345,226	0	345,226		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,397	2,521,993	0	2,521,993		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	317,958	0	317,958		192.00
192.01	19201	OCCUPATIONAL MEDICINE	76	42,432	0	42,432		192.01
192.02	19202	VACANT SPACE	0	0	0	0		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	63,473	2,882,383	0	2,882,383		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - INTERES (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	196,565					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	0	172,228				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			201,311			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	871	871	871	11,443,386		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,355	12,355	12,355	770,493	-8,422,463	5.00
7.00	00700	OPERATION OF PLANT	47,302	41,501	47,302	891,983	0	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,213	3,213	3,213	59,571	0	8.00
9.00	00900	HOUSEKEEPING	1,917	1,917	1,917	351,341	0	9.00
10.00	01000	DIETARY	2,267	2,267	2,267	103,891	0	10.00
11.00	01100	CAFETERIA	6,135	6,135	6,135	281,182	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,387	4,387	4,387	802,245	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,158	4,158	4,158	0	0	14.00
15.00	01500	PHARMACY	2,283	2,283	2,283	711,978	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,070	19,070	23,816	1,882,063	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,247	24,247	24,247	1,010,847	0	50.00
53.00	05300	ANESTHESIOLOGY	457	457	457	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,682	12,682	12,682	1,072,407	0	54.00
60.00	06000	LABORATORY	4,955	4,955	4,955	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	300	300	300	533,410	0	65.00
66.00	06600	PHYSICAL THERAPY	6,999	2,515	6,999	687,793	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,318	833	2,318	237,318	0	67.00
68.00	06800	SPEECH PATHOLOGY	88	32	88	24,878	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,297	3,297	3,297	504,218	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	1,987	1,987	1,987	216,393	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,163	2,163	2,163	79,584	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	14,039	14,039	14,039	1,063,963	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	177,490	165,664	182,236	11,285,558	-8,422,463	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,258	4,747	17,258	104,443	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,817	1,817	1,817	53,385	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	1,559,457	108,173	1,214,753	2,579,402		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.933544	0.628080	6.034211	0.225405		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				12,713		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001111		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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,300,354					5.00
7.00	00700	OPERATION OF PLANT	5,249,737	123,831				7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	12,206			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	178,080	3,213	0	1,938		8.00
9.00	00900	HOUSEKEEPING	509,695	1,917	0	0	130,907	9.00
10.00	01000	DIETARY	277,318	2,267	0	0	2,267	10.00
11.00	01100	CAFETERIA	613,563	6,135	0	0	6,135	11.00
13.00	01300	NURSING ADMINISTRATION	1,151,298	4,387	0	0	4,387	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	768,264	4,158	0	0	4,158	14.00
15.00	01500	PHARMACY	1,028,044	2,283	0	0	2,283	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,787,330	19,070	0	1,938	19,070	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,798,784	24,247	0	0	24,247	50.00
53.00	05300	ANESTHESIOLOGY	66,090	457	0	0	457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,646,432	12,682	0	0	12,682	54.00
60.00	06000	LABORATORY	1,484,185	4,955	0	0	4,955	60.00
65.00	06500	RESPIRATORY THERAPY	702,880	300	0	0	300	65.00
66.00	06600	PHYSICAL THERAPY	1,023,246	2,515	4,484	0	6,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	338,259	833	1,485	0	2,318	67.00
68.00	06800	SPEECH PATHOLOGY	34,498	32	56	0	88	68.00
69.00	06900	ELECTROCARDIOLOGY	698,626	3,297	0	0	3,297	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	409,034	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,200,134	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,996,998	0	0	0	0	73.00
73.01	03480	ONCOLOGY	331,163	1,987	0	0	1,987	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,197,921	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	133,881	2,163	0	0	2,163	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,140,435	14,039	0	0	14,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,765,895	110,937	6,025	1,938	111,832	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	384,587	11,077	6,181	0	17,258	192.00
192.01	19201	OCCUPATIONAL MEDICINE	149,872	1,817	0	0	1,817	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	8,422,463	6,708,980	0	401,656	755,233	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.277966	54.178517	0.000000	207.252838	5.769233	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	181,188	719,145	0	66,686	42,552	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005980	5.807471	0.000000	34.409701	0.325055	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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/9/2021 10:17 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	6,594					10.00
11.00	01100	CAFETERIA	0	13,549				11.00
13.00	01300	NURSING ADMINISTRATION	0	801	97,049			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,395,604		14.00
15.00	01500	PHARMACY	0	816	0	34,637	5,240,808	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,594	3,145	42,353	85,193	7,018	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,453	20,651	462,438	10,491	50.00
53.00	05300	ANESTHESIOLOGY	0	100	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,513	0	18,579	1,574	54.00
60.00	06000	LABORATORY	0	981	0	24,030	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	661	0	36,164	235	65.00
66.00	06600	PHYSICAL THERAPY	0	867	0	13,238	234	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	326	0	621	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	29	0	23	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	594	7,224	9,295	171	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	409,034	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,200,134	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,996,998	73.00
73.01	03480	ONCOLOGY	0	296	2,836	13,336	2,769	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	1,197,921	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	103	2,141	991	9	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,591	19,497	85,593	17,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,594	13,276	94,702	2,393,306	5,234,510	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	160	0	487	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	113	2,347	1,811	6,298	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	490,305	1,151,892	1,802,409	1,231,077	1,537,840	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	74.356233	85.016754	18.572154	0.513890	0.293436	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,765	131,149	106,463	90,783	63,473	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.395359	9.679607	1.097003	0.037896	0.012111	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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,697,080		6,697,080	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,500,120		4,500,120	0	0	50.00
53.00	05300	ANESTHESIOLOGY	120,360		120,360	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,002,981		3,002,981	0	0	54.00
60.00	06000	LABORATORY	2,289,530		2,289,530	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	991,091	0	991,091	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,564,894	0	1,564,894	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	518,822	0	518,822	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,806	0	48,806	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,279,960		1,279,960	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	732,930		732,930	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,150,467		2,150,467	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,280,889		6,280,889	0	0	73.00
73.01	03480	ONCOLOGY	627,833		627,833	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,882,415		1,882,415	0	0	73.02
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	349,794		349,794	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,123,372		4,123,372	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,023,458		1,023,458		0	92.00
200.00		Subtotal (see instructions)	38,184,802	0	38,184,802	0	0	200.00
201.00		Less Observation Beds	1,023,458		1,023,458		0	201.00
202.00		Total (see instructions)	37,161,344	0	37,161,344	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,570,756		4,570,756			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,599,178	20,007,066	24,606,244	0.182885	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	224,787	1,259,903	1,484,690	0.081067	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	385,667	7,799,822	8,185,489	0.366866	0.000000	54.00
60.00	06000	LABORATORY	713,223	4,018,786	4,732,009	0.483839	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	462,482	499,765	962,247	1.029976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	589,458	1,405,551	1,995,009	0.784404	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	266,486	463,186	729,672	0.711035	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,496	41,728	75,224	0.648809	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	272,272	3,629,773	3,902,045	0.328023	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	923,627	3,013,229	3,936,856	0.186171	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,722,284	7,269,787	13,992,071	0.153692	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,333,335	17,192,145	19,525,480	0.321677	0.000000	73.00
73.01	03480	ONCOLOGY	840	2,576,705	2,577,545	0.243578	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	10,314,240	10,314,240	0.182506	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	514,367	514,367	0.680048	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	317,400	11,796,706	12,114,106	0.340378	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	15,975	1,959,019	1,974,994	0.518208	0.000000	92.00
200.00		Subtotal (see instructions)	22,431,266	93,761,778	116,193,044			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,431,266	93,761,778	116,193,044			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000		73.02
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,697,080		6,697,080	0	6,697,080	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,500,120		4,500,120	0	4,500,120	50.00
53.00	05300	ANESTHESIOLOGY	120,360		120,360	0	120,360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,002,981		3,002,981	0	3,002,981	54.00
60.00	06000	LABORATORY	2,289,530		2,289,530	0	2,289,530	60.00
65.00	06500	RESPIRATORY THERAPY	991,091	0	991,091	0	991,091	65.00
66.00	06600	PHYSICAL THERAPY	1,564,894	0	1,564,894	0	1,564,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	518,822	0	518,822	0	518,822	67.00
68.00	06800	SPEECH PATHOLOGY	48,806	0	48,806	0	48,806	68.00
69.00	06900	ELECTROCARDIOLOGY	1,279,960		1,279,960	0	1,279,960	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	732,930		732,930	0	732,930	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,150,467		2,150,467	0	2,150,467	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,280,889		6,280,889	0	6,280,889	73.00
73.01	03480	ONCOLOGY	627,833		627,833	0	627,833	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,882,415		1,882,415	0	1,882,415	73.02
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	349,794		349,794	0	349,794	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,123,372		4,123,372	0	4,123,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,023,458		1,023,458		1,023,458	92.00
200.00		Subtotal (see instructions)	38,184,802	0	38,184,802	0	38,184,802	200.00
201.00		Less Observation Beds	1,023,458		1,023,458		1,023,458	201.00
202.00		Total (see instructions)	37,161,344	0	37,161,344	0	37,161,344	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,570,756		4,570,756			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,599,178	20,007,066	24,606,244	0.182885	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	224,787	1,259,903	1,484,690	0.081067	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	385,667	7,799,822	8,185,489	0.366866	0.000000	54.00
60.00	06000	LABORATORY	713,223	4,018,786	4,732,009	0.483839	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	462,482	499,765	962,247	1.029976	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	589,458	1,405,551	1,995,009	0.784404	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	266,486	463,186	729,672	0.711035	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,496	41,728	75,224	0.648809	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	272,272	3,629,773	3,902,045	0.328023	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	923,627	3,013,229	3,936,856	0.186171	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,722,284	7,269,787	13,992,071	0.153692	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,333,335	17,192,145	19,525,480	0.321677	0.000000	73.00
73.01	03480	ONCOLOGY	840	2,576,705	2,577,545	0.243578	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	10,314,240	10,314,240	0.182506	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	514,367	514,367	0.680048	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	317,400	11,796,706	12,114,106	0.340378	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	15,975	1,959,019	1,974,994	0.518208	0.000000	92.00
200.00		Subtotal (see instructions)	22,431,266	93,761,778	116,193,044			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,431,266	93,761,778	116,193,044			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000		73.02
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	568,852	24,606,244	0.023118	3,029,493	70,036	50.00
53.00	05300	ANESTHESIOLOGY	10,837	1,484,690	0.007299	145,967	1,065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	289,281	8,185,489	0.035341	159,211	5,627	54.00
60.00	06000	LABORATORY	121,992	4,732,009	0.025780	343,150	8,846	60.00
65.00	06500	RESPIRATORY THERAPY	18,785	962,247	0.019522	245,379	4,790	65.00
66.00	06600	PHYSICAL THERAPY	132,001	1,995,009	0.066166	294,847	19,509	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,958	729,672	0.060244	131,797	7,940	67.00
68.00	06800	SPEECH PATHOLOGY	1,980	75,224	0.026321	19,434	512	68.00
69.00	06900	ELECTROCARDIOLOGY	87,109	3,902,045	0.022324	127,216	2,840	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,947	3,936,856	0.004559	601,302	2,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,655	13,992,071	0.003763	4,736,867	17,825	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,311	19,525,480	0.003703	1,085,241	4,019	73.00
73.01	03480	ONCOLOGY	49,922	2,577,545	0.019368	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	21,672	10,314,240	0.002101	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	49,109	514,367	0.095475	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	345,226	12,114,106	0.028498	2,839	81	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	97,555	1,974,994	0.049395	0	0	92.00
200.00		Total (lines 50 through 199)	1,981,192	111,622,288		10,922,743	145,831	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV | Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	24,606,244	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,484,690	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,185,489	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,732,009	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	962,247	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,995,009	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	729,672	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	75,224	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,902,045	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,936,856	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,992,071	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,525,480	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	2,577,545	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	10,314,240	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	514,367	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	12,114,106	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,974,994	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	111,622,288		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,029,493	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	145,967	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	159,211	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	343,150	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	245,379	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	294,847	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	131,797	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	19,434	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	127,216	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	601,302	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,736,867	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,085,241	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	2,839	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)		10,922,743	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.182885	0	3,303,378	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.081067	0	128,122	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366866	0	2,325,822	0	0	54.00
60.00	06000	LABORATORY	0.483839	0	1,229,369	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.029976	0	183,632	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.784404	0	471,942	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.711035	0	97,477	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.648809	0	12,823	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.328023	0	1,255,633	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.186171	0	803,643	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.153692	0	1,356,835	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321677	0	9,553,686	150	0	73.00
73.01	03480	ONCOLOGY	0.243578	0	1,181,214	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.182506	0	3,402,078	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.680048	0	196,939	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.340378	0	3,467,733	1,284	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.518208	0	731,569	339	0	92.00
200.00		Subtotal (see instructions)		0	29,701,895	1,773	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	29,701,895	1,773	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	604,138	0		50.00
53.00	05300	ANESTHESIOLOGY	10,386	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	853,265	0		54.00
60.00	06000	LABORATORY	594,817	0		60.00
65.00	06500	RESPIRATORY THERAPY	189,137	0		65.00
66.00	06600	PHYSICAL THERAPY	370,193	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	69,310	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,320	0		68.00
69.00	06900	ELECTROCARDIOLOGY	411,877	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,615	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,535	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,073,201	48		73.00
73.01	03480	ONCOLOGY	287,718	0		73.01
73.02	07301	BLOOD DISORDER DRUGS	620,900	0		73.02
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	133,928	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,180,340	437		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	379,105	176		92.00
200.00		Subtotal (see instructions)	9,144,785	661		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,144,785	661		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.182885	0	283,026	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.081067	0	37,845	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366866	0	39,529	0	0	54.00
60.00	06000	LABORATORY	0.483839	0	28,634	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.029976	0	2,522	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.784404	0	1,601	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.711035	0	1,581	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.648809	0	286	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.328023	0	26,760	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.186171	0	669	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.153692	0	956	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321677	0	29,304	0	0	73.00
73.01	03480	ONCOLOGY	0.243578	0	21,448	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.182506	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.680048	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.340378	0	138,350	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.518208	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	612,511	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	612,511	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	51,761	0		50.00
53.00	05300	ANESTHESIOLOGY	3,068	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,502	0		54.00
60.00	06000	LABORATORY	13,854	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,598	0		65.00
66.00	06600	PHYSICAL THERAPY	1,256	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,124	0		67.00
68.00	06800	SPEECH PATHOLOGY	186	0		68.00
69.00	06900	ELECTROCARDIOLOGY	8,778	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	147	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,426	0		73.00
73.01	03480	ONCOLOGY	5,224	0		73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0		73.02
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	47,091	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	159,140	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	159,140	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/9/2021 10:17 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,328	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)	1,938	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	224	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	36	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,146	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)	224	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,697,080	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	587,832	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,109,248	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,109,248	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,624.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,007,391	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)	3,007,391	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	2,612,411	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,619,802	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)	587,832	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)	587,832	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)	390	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,624.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,023,458	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	638,356	6,697,080	0.095319	1,023,458	97,555	90.00
91.00	Nursing School cost	0	6,697,080	0.000000	1,023,458	0	91.00
92.00	Allied health cost	0	6,697,080	0.000000	1,023,458	0	92.00
93.00	All other Medical Education	0	6,697,080	0.000000	1,023,458	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,588	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,328	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)	1,938	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	224	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	36	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)	4	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,697,080	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	587,832	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,109,248	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,109,248	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,624.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	10,497	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	10,497	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	3,219	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	13,716	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	390	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,624.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,023,458	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	638,356	6,697,080	0.095319	1,023,458	97,555	90.00
91.00	Nursing School cost	0	6,697,080	0.000000	1,023,458	0	91.00
92.00	Allied health cost	0	6,697,080	0.000000	1,023,458	0	92.00
93.00	All other Medical Education	0	6,697,080	0.000000	1,023,458	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,553,933		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.182885	3,029,493	554,049	50.00
53.00	05300	ANESTHESIOLOGY	0.081067	145,967	11,833	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366866	159,211	58,409	54.00
60.00	06000	LABORATORY	0.483839	343,150	166,029	60.00
65.00	06500	RESPIRATORY THERAPY	1.029976	245,379	252,734	65.00
66.00	06600	PHYSICAL THERAPY	0.784404	294,847	231,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.711035	131,797	93,712	67.00
68.00	06800	SPEECH PATHOLOGY	0.648809	19,434	12,609	68.00
69.00	06900	ELECTROCARDIOLOGY	0.328023	127,216	41,730	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.186171	601,302	111,945	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.153692	4,736,867	728,019	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321677	1,085,241	349,097	73.00
73.01	03480	ONCOLOGY	0.243578	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.182506	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.680048	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.340378	2,839	966	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.518208	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,922,743	2,612,411	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)		10,922,743		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.182885	3,060	560	50.00
53.00	05300	ANESTHESIOLOGY	0.081067	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366866	4,044	1,484	54.00
60.00	06000	LABORATORY	0.483839	18,755	9,074	60.00
65.00	06500	RESPIRATORY THERAPY	1.029976	17,547	18,073	65.00
66.00	06600	PHYSICAL THERAPY	0.784404	100,927	79,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.711035	51,842	36,861	67.00
68.00	06800	SPEECH PATHOLOGY	0.648809	2,973	1,929	68.00
69.00	06900	ELECTROCARDIOLOGY	0.328023	7,214	2,366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.186171	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.153692	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321677	76,581	24,634	73.00
73.01	03480	ONCOLOGY	0.243578	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.182506	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.680048	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.340378	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.518208	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		282,943	174,149	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)		282,943		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/9/2021 10:17 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,764		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.182885	284	52	50.00
53.00	05300	ANESTHESIOLOGY	0.081067	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366866	2,549	935	54.00
60.00	06000	LABORATORY	0.483839	253	122	60.00
65.00	06500	RESPIRATORY THERAPY	1.029976	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.784404	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.711035	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.648809	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.328023	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.186171	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.153692	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.321677	1,186	382	73.00
73.01	03480	ONCOLOGY	0.243578	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.182506	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.680048	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.340378	5,076	1,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.518208	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,348	3,219	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)		9,348		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,145,446	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)	9,145,446	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)	9,236,900	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)	37,869	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,607,162	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)	3,591,869	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)	3,591,869	30.00
31.00	Primary payer payments	2,087	31.00
32.00	Subtotal (line 30 minus line 31)	3,589,782	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)	232,175	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	150,914	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,236	36.00
37.00	Subtotal (see instructions)	3,740,696	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)	3,740,696	40.00
40.01	Sequestration adjustment (see instructions)	24,689	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,672,270	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)	-956,263	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	271,443	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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,282,161		4,522,270	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	08/31/2020	177,900	08/31/2020	150,000	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)		177,900		150,000	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)		4,460,061		4,672,270	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		867,498		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		956,263	6.02
7.00	Total Medicare program liability (see instructions)		5,327,559		3,716,007	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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I | Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		615,613		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)		615,613		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		148,383		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		763,996		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: 15-1311	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/9/2021 10:17 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-2 | Date/Time Prepared: 7/9/2021 10:17 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	593,710	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)	175,890	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	224	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)	769,600	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	769,600	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)	769,600	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	528	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	769,072	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)	769,072	0	19.00
19.01	Sequestration adjustment (see instructions)	5,076	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	615,613	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)	148,383	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	24,394	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: 15-1311	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 7/9/2021 10:17 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,619,802	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)	5,619,802	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,676,000	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)	5,676,000	19.00
20.00	Deductibles (exclude professional component)	333,652	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,342,348	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,342,348	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,702	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,606	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,211	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,362,954	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)	5,362,954	30.00
30.01	Sequestration adjustment (see instructions)	35,395	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	4,460,061	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)	867,498	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	175,678	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/9/2021 10:17 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	41,706,628	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	5,940,100	0	0	0	4.00
5.00	Other receivable	-1,811,257	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,015,955	0	0	0	7.00
8.00	Prepaid expenses	141,328	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)	46,992,754	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,316,325	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,872,457	0	0	0	17.00
18.00	Accumulated depreciation	-1,433,128	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,175,222	0	0	0	23.00
24.00	Accumulated depreciation	-9,624,310	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)	13,306,566	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	955,708	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	14,777,828	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,733,536	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	76,032,856	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,202,807	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,514,089	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	7,779,802				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,327,025	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,823,723	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,935,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	508,503	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,443,503	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,267,226	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	47,765,630				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)	47,765,630	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	76,032,856	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/9/2021 10:17 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		39,686,882		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,464,100				2.00
3.00	Total (sum of line 1 and line 2)		46,150,982		0		3.00
4.00	DONATED PROP., PLANT, EQUIP.	11,039		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)		11,039		0		10.00
11.00	Subtotal (line 3 plus line 10)		46,162,021		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	PERM RESTRICTED	-1,800		0		0	14.00
15.00	TEMP RESTRICTED	-1,601,809		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		-1,603,609		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		47,765,630		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	DONATED PROP., PLANT, EQUIP.		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	PERM RESTRICTED		0		14.00
15.00	TEMP RESTRICTED		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: 15-1311 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/9/2021 10:17 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,348,976		4,348,976	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	221,780		221,780	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)	4,570,756		4,570,756	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,570,756		4,570,756	17.00
18.00	Ancillary services	17,527,135	80,006,052	97,533,187	18.00
19.00	Outpatient services	333,375	13,755,725	14,089,100	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NONALLOWABLE REVENUE	0	1,913,192	1,913,192	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,431,266	95,674,969	118,106,235	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,890,779		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)		41,890,779		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Prepared: 7/9/2021 10:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	118,106,235	1.00
2.00	Less contractual allowances and discounts on patients' accounts	71,912,123	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,194,112	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,890,779	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,303,333	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	MISCELLANEOUS INCOME	1,798,932	24.00
24.50	COVID-19 PHE Funding	361,835	24.50
25.00	Total other income (sum of lines 6-24)	2,160,767	25.00
26.00	Total (line 5 plus line 25)	6,464,100	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)	6,464,100	29.00