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: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/27/2021 8:18 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/27/2021 Time: 8:18 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Laffayette Regional Rehabilitation Hospital (15-3042) 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) CLINT FEGAN
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	996	0	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	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	996	0	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/27/2021 8:18 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 950 Park East Blvd	PO Box:			1.00
2.00	City: Lafayette	State: IN	Zip Code: 47905	County: TIPPECANOE	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	Laffayette Regional Rehabilitation Hospital	153042	29200	5	04/18/2013	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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)	4		21.00

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

		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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I Date/Time Prepared: 7/27/2021 8:18 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
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.	191	100	0	0	373		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/27/2021 8:18 pm

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

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

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

		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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/27/2021 8:18 pm

		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.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/27/2021 8:18 pm

		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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		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)			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)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1609	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part I | Date/Time Prepared: 7/27/2021 8:18 pm

	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: ERNEST HEALTH INC	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 04011	141.00
142.00	Street: PO BOX 93758	PO Box:		142.00
143.00	City: ALBUQUERQUE	State: NM	Zip Code: 87199	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N	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.	Y		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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II | Date/Time Prepared: 7/27/2021 8:18 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/05/2021	Y	05/05/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Prepared: 7/27/2021 8:18 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	Mary	Pitcock	41.00
42.00	Enter the employer/company name of the cost report preparer.	ERNEST HEALTH INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	903-588-0077	marykay@ernesthealth.com	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/27/2021 8:18 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	Sr. Reimbursement Analyst		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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I Date/Time Prepared: 7/27/2021 8:18 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,640	0.00	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)		40	14,640	0.00	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)		40	14,640	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		40				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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/27/2021 8:18 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,658	191	7,431			1.00
2.00	HMO and other (see instructions)	1,181	473				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,658	191	7,431			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)	4,658	191	7,431	0.00	96.53	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	96.53	27.00
28.00	Observation Bed Days		0	0			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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-3 Part I | Date/Time Prepared: 7/27/2021 8:18 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	310	12	481	1.00
2.00	HMO and other (see instructions)			74	24		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	310	12	481	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,647,086	1,647,086	7,493	1,654,579	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		206,087	206,087	206,728	412,815	2.00
3.00	00300	OTHER CAP REL COSTS		214,221	214,221	-214,221	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	566,318	903,439	1,469,757	0	1,469,757	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,554,113	1,788,745	3,342,858	0	3,342,858	5.00
7.00	00700	OPERATION OF PLANT	48,100	408,281	456,381	0	456,381	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,520	34,520	0	34,520	8.00
9.00	00900	HOUSEKEEPING	128,130	39,413	167,543	0	167,543	9.00
10.00	01000	DIETARY	230,005	181,337	411,342	0	411,342	10.00
13.00	01300	NURSING ADMINISTRATION	288,715	24,604	313,319	0	313,319	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,481	20,186	48,667	0	48,667	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,144,978	227,527	2,372,505	0	2,372,505	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,632	28,632	0	28,632	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	89,683	89,683	0	89,683	60.00
65.00	06500	RESPIRATORY THERAPY	96,899	41,922	138,821	0	138,821	65.00
66.00	06600	PHYSICAL THERAPY	489,360	71,094	560,454	31,332	591,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	365,226	36,318	401,544	130,316	531,860	67.00
68.00	06800	SPEECH PATHOLOGY	145,803	13,958	159,761	55,172	214,933	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,089	158,576	195,665	0	195,665	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	199,207	295,193	494,400	0	494,400	73.00
74.00	07400	RENAL DIALYSIS	0	136,595	136,595	0	136,595	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	137,554	137,554	0	137,554	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	214,318	2,502	216,820	-216,820	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,536,742	6,707,473	13,244,215	0	13,244,215	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	6,536,742	6,707,473	13,244,215	0	13,244,215	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A | Date/Time Prepared: 7/27/2021 8:18 pm

		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	219,753	1,874,332		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,200	414,015		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,491	1,462,266		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	157,646	3,500,504		5.00
7.00	00700	OPERATION OF PLANT	-7,078	449,303		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,520		8.00
9.00	00900	HOUSEKEEPING	0	167,543		9.00
10.00	01000	DIETARY	-9,016	402,326		10.00
13.00	01300	NURSING ADMINISTRATION	0	313,319		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-55	48,612		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,372,505		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,632		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	89,683		60.00
65.00	06500	RESPIRATORY THERAPY	0	138,821		65.00
66.00	06600	PHYSICAL THERAPY	0	591,786		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	531,860		67.00
68.00	06800	SPEECH PATHOLOGY	0	214,933		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-25	195,640		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	494,400		73.00
74.00	07400	RENAL DIALYSIS	0	136,595		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	137,554		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
91.01	04951	OUTPATIENT THERAPY	0	0		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	354,934	13,599,149		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	354,934	13,599,149		200.00

RECLASSIFICATIONS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/27/2021 8:18 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RCLS PCT THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	43,529	4,134	1.00
2.00	SPEECH PATHOLOGY	68.00	18,429	1,750	2.00
	TOTALS		61,958	5,884	
	B - RCLS O/P THERAPY				
1.00	PHYSICAL THERAPY	66.00	98,030	1,144	1.00
2.00	OCCUPATIONAL THERAPY	67.00	81,699	954	2.00
3.00	SPEECH PATHOLOGY	68.00	34,589	404	3.00
	TOTALS		214,318	2,502	
500.00	Grand Total: Increases		276,276	8,386	500.00

RECLASSIFICATIONS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-6 | Date/Time Prepared: 7/27/2021 8:18 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RCLS PCT THERAPY						
1.00	PHYSICAL THERAPY	66.00	61,958	5,884	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		61,958	5,884			
	B - RCLS O/P THERAPY						
1.00	OUTPATIENT THERAPY	91.01	214,318	2,502	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		214,318	2,502			
500.00	Grand Total: Decreases		276,276	8,386			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part I | Date/Time Prepared: 7/27/2021 8:18 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,647	56,539	0	56,539	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	20,680	0	0	0	0	5.00
6.00	Movable Equipment	2,324,835	402,990	0	402,990	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,367,162	459,529	0	459,529	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,367,162	459,529	0	459,529	0	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	78,186	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	20,680	0	5.00
6.00	Movable Equipment	2,727,825	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,826,691	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	2,826,691	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part II | Date/Time Prepared: 7/27/2021 8:18 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	9,400	1,602,606	35,080	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	157,496	48,591	0	0	0	2.00
3.00	Total (sum of lines 1-2)	166,896	1,651,197	35,080	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	1,647,086	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	206,087	2.00
3.00	Total (sum of lines 1-2)	0	1,853,173	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-7 Part III Date/Time Prepared: 7/27/2021 8:18 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	98,866	0	98,866	0.034976	304	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,727,825	0	2,727,825	0.965024	8,376	2.00
3.00	Total (sum of lines 1-2)	2,826,691	0	2,826,691	1.000000	8,680	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,189	0	7,493	229,153	1,602,606	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	198,352	0	206,728	158,696	48,591	2.00
3.00	Total (sum of lines 1-2)	205,541	0	214,221	387,849	1,651,197	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	35,080	304	7,189	0	1,874,332	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,376	198,352	0	414,015	2.00
3.00	Total (sum of lines 1-2)	35,080	8,680	205,541	0	2,288,347	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/27/2021 8:18 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,343	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,796	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	1,251,143			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-9,005	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-51	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INTEREST INCOME	B	-143	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8 | Date/Time Prepared: 7/27/2021 8:18 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISC INCOME	B	-10,954	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.11	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-4,797	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13	OTHER EXPENSE-ADVERTISING/MARKETING-	A	-7,994	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.29	BAD DEBT EXPENSE-BAD DEBT--	A	-109,374	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.72	OTHER EXPENSE-COMMUNITY EVENTS--	A	-2	ADMINISTRATIVE & GENERAL	5.00	0	33.72
33.73	OTHER EXPENSE-COMMUNITY EVENTS--	A	320	ADMINISTRATIVE & GENERAL	5.00	0	33.73
33.82	OTHER EXPENSE-CONTRIBUTIONS / SPONSO	A	88	ADMINISTRATIVE & GENERAL	5.00	0	33.82
33.83	OTHER EXPENSE-CONTRIBUTIONS / SPONSO	A	-700	ADMINISTRATIVE & GENERAL	5.00	0	33.83
33.91	OTHER EXPENSE-FLOWERS & GIFTS--	A	-315	ADMINISTRATIVE & GENERAL	5.00	0	33.91
34.17	TAXES-FRANCHISE FEES/BUSINESS TAX--	A	-300	ADMINISTRATIVE & GENERAL	5.00	0	34.17
34.22	OTHER EXPENSE-GIVEAWAYS--	A	-940	ADMINISTRATIVE & GENERAL	5.00	0	34.22
34.24	OTHER EXPENSE-GIVEAWAYS--	A	-673	ADMINISTRATIVE & GENERAL	5.00	0	34.24
34.48	OTHER FEES-LATE FEES--	A	-93	ADMINISTRATIVE & GENERAL	5.00	0	34.48
34.65	OTHER FEES-LATE FEES--	A	-282	OPERATION OF PLANT	7.00	0	34.65
34.69	OTHER FEES-LATE FEES--	A	-11	DIETARY	10.00	0	34.69
34.74	OTHER FEES-LATE FEES--	A	-4	MEDICAL RECORDS & LIBRARY	16.00	0	34.74
34.77	OTHER FEES-LATE FEES--	A	-25	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	34.77
35.23	MARKETING EXPENSE	A	-58,284	ADMINISTRATIVE & GENERAL	5.00	0	35.23
35.24	MARKETING BENEFITS	A	-6,951	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.24
35.25	TELEPHONE OPERATOR EXPENSE	A	-20,852	ADMINISTRATIVE & GENERAL	5.00	0	35.25
35.26	TELEPHONE BENEFIT EXPENSE	A	-540	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.26
35.28	UNALLOWABLE LOBBYING % OF ASSOC DUES	A	-441	ADMINISTRATIVE & GENERAL	5.00	0	35.28
35.29	PHYSICIAN CONTRACT	A	-655,747	ADMINISTRATIVE & GENERAL	5.00	0	35.29
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		354,934				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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet A-8-1 | Date/Time Prepared: 7/27/2021 8:18 pm

	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	HO Alloc - Cap Rel Bldg	219,753	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO Alloc - Cap Rel Equipment	1,200	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO Alloc - Cap Rel A&G	1,266,830	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY MANAGEMENT FEES	0	236,640	4.00
5.00	0		0	1,487,783	236,640	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	ERNEST 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:	FINANCIAL				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: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 7/27/2021 8:18 pm

	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	219,753	9		1.00
2.00	1,200	9		2.00
3.00	1,266,830	0		3.00
4.00	-236,640	0		4.00
5.00	1,251,143			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,874,332	1,874,332				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	414,015		414,015			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,462,266	7,540	1,666	1,471,472		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,500,504	124,495	27,499	383,027	4,035,525	5.00
7.00	00700	OPERATION OF PLANT	449,303	431,058	95,215	11,855	987,431	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,520	0	0	0	34,520	8.00
9.00	00900	HOUSEKEEPING	167,543	12,214	2,698	31,579	214,034	9.00
10.00	01000	DIETARY	402,326	172,015	37,996	56,687	669,024	10.00
13.00	01300	NURSING ADMINISTRATION	313,319	19,676	4,346	71,157	408,498	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,612	20,422	4,511	7,019	80,564	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,372,505	764,875	168,951	528,651	3,834,982	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,632	0	0	0	28,632	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	89,683	0	0	0	89,683	60.00
65.00	06500	RESPIRATORY THERAPY	138,821	7,855	1,735	23,882	172,293	65.00
66.00	06600	PHYSICAL THERAPY	591,786	132,506	29,269	129,498	883,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	531,860	76,071	16,803	120,878	745,612	67.00
68.00	06800	SPEECH PATHOLOGY	214,933	8,640	1,908	49,001	274,482	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	195,640	18,065	3,990	9,141	226,836	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	494,400	21,993	4,858	49,097	570,348	73.00
74.00	07400	RENAL DIALYSIS	136,595	0	0	0	136,595	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	137,554	0	0	0	137,554	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,599,149	1,817,425	401,445	1,471,472	13,529,672	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,082	12,388	0	68,470	192.00
194.00	07950	MARKETING	0	825	182	0	1,007	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	13,599,149	1,874,332	414,015	1,471,472	13,599,149	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,035,525					5.00
7.00	00700	OPERATION OF PLANT	416,662	1,404,093				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,566	0	49,086			8.00
9.00	00900	HOUSEKEEPING	90,315	13,079	0	317,428		9.00
10.00	01000	DIETARY	282,305	184,196	0	42,033	1,177,558	10.00
13.00	01300	NURSING ADMINISTRATION	172,372	21,069	0	4,808	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,995	21,868	0	4,990	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,618,235	819,039	49,086	186,905	1,177,558	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,082	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	37,843	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	72,702	8,411	0	1,919	0	65.00
66.00	06600	PHYSICAL THERAPY	372,621	141,890	0	32,379	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	314,623	81,458	0	18,589	0	67.00
68.00	06800	SPEECH PATHOLOGY	115,822	9,252	0	2,111	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,717	19,345	0	4,414	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	240,667	23,550	0	5,374	0	73.00
74.00	07400	RENAL DIALYSIS	57,638	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	58,043	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,006,208	1,343,157	49,086	303,522	1,177,558	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,892	60,053	0	13,704	0	192.00
194.00	07950	MARKETING	425	883	0	202	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	4,035,525	1,404,093	49,086	317,428	1,177,558	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	606,747					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	141,417				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	606,747	56,211	8,348,763	0	8,348,763	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,560	43,274	0	43,274	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	5,813	133,339	0	133,339	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,066	259,391	0	259,391	65.00
66.00	06600	PHYSICAL THERAPY	0	21,894	1,451,843	0	1,451,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,247	1,178,529	0	1,178,529	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,725	409,392	0	409,392	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,443	350,755	0	350,755	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,414	857,353	0	857,353	73.00
74.00	07400	RENAL DIALYSIS	0	2,205	196,438	0	196,438	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	839	196,436	0	196,436	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	606,747	141,417	13,425,513	0	13,425,513	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	171,119	0	171,119	192.00
194.00	07950	MARKETING	0	0	2,517	0	2,517	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	606,747	141,417	13,599,149	0	13,599,149	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,540	1,666	9,206	9,206	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	124,495	27,499	151,994	2,396	5.00
7.00	00700	OPERATION OF PLANT	0	431,058	95,215	526,273	74	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	12,214	2,698	14,912	198	9.00
10.00	01000	DIETARY	0	172,015	37,996	210,011	355	10.00
13.00	01300	NURSING ADMINISTRATION	0	19,676	4,346	24,022	445	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,422	4,511	24,933	44	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	764,875	168,951	933,826	3,308	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,855	1,735	9,590	149	65.00
66.00	06600	PHYSICAL THERAPY	0	132,506	29,269	161,775	810	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	76,071	16,803	92,874	756	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,640	1,908	10,548	307	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,065	3,990	22,055	57	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,993	4,858	26,851	307	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,817,425	401,445	2,218,870	9,206	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,082	12,388	68,470	0	192.00
194.00	07950	MARKETING	0	825	182	1,007	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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	1,874,332	414,015	2,288,347	9,206	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	154,390					5.00
7.00	00700	OPERATION OF PLANT	15,940	542,287				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	557	0	557			8.00
9.00	00900	HOUSEKEEPING	3,455	5,051	0	23,616		9.00
10.00	01000	DIETARY	10,800	71,140	0	3,127	295,433	10.00
13.00	01300	NURSING ADMINISTRATION	6,594	8,137	0	358	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,301	8,446	0	371	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,914	316,329	557	13,905	295,433	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	462	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,448	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,781	3,248	0	143	0	65.00
66.00	06600	PHYSICAL THERAPY	14,255	54,800	0	2,409	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,036	31,461	0	1,383	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,431	3,573	0	157	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,662	7,471	0	328	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,207	9,096	0	400	0	73.00
74.00	07400	RENAL DIALYSIS	2,205	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	2,221	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,269	518,752	557	22,581	295,433	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,105	23,194	0	1,020	0	192.00
194.00	07950	MARKETING	16	341	0	15	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	154,390	542,287	557	23,616	295,433	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part II Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			13.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION	39,556					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,095				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,556	13,954	1,678,782	0	1,678,782	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	635	1,097	0	1,097	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,442	2,890	0	2,890	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,009	16,920	0	16,920	65.00
66.00	06600	PHYSICAL THERAPY	0	5,432	239,481	0	239,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,527	143,037	0	143,037	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,917	20,933	0	20,933	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,103	34,676	0	34,676	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,321	50,182	0	50,182	73.00
74.00	07400	RENAL DIALYSIS	0	547	2,752	0	2,752	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	208	2,429	0	2,429	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,556	35,095	2,193,179	0	2,193,179	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	93,789	0	93,789	192.00
194.00	07950	MARKETING	0	0	1,379	0	1,379	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,556	35,095	2,288,347	0	2,288,347	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	47,726					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		47,726				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	192	192	5,970,423			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,170	3,170	1,554,113	-4,035,525	9,563,624	5.00
7.00	00700	OPERATION OF PLANT	10,976	10,976	48,100	0	987,431	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	34,520	8.00
9.00	00900	HOUSEKEEPING	311	311	128,130	0	214,034	9.00
10.00	01000	DIETARY	4,380	4,380	230,005	0	669,024	10.00
13.00	01300	NURSING ADMINISTRATION	501	501	288,715	0	408,498	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520	520	28,481	0	80,564	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,476	19,476	2,144,977	0	3,834,982	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	28,632	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	89,683	60.00
65.00	06500	RESPIRATORY THERAPY	200	200	96,899	0	172,293	65.00
66.00	06600	PHYSICAL THERAPY	3,374	3,374	525,431	0	883,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,937	1,937	490,455	0	745,612	67.00
68.00	06800	SPEECH PATHOLOGY	220	220	198,821	0	274,482	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	460	37,089	0	226,836	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560	560	199,207	0	570,348	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	136,595	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	137,554	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,277	46,277	5,970,423	-4,035,525	9,494,147	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	1,428	0	0	68,470	192.00
194.00	07950	MARKETING	21	21	0	0	1,007	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	1,874,332	414,015	1,471,472		4,035,525	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.272765	8.674831	0.246460		0.421966	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,206		154,390	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001542		0.016143	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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	NURSING ADMINISTRATION (NURSING SALARIES)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	33,388					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,431				8.00
9.00	00900	HOUSEKEEPING	311	0	33,077			9.00
10.00	01000	DIETARY	4,380	0	4,380	7,431		10.00
13.00	01300	NURSING ADMINISTRATION	501	0	501	0	2,144,977	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520	0	520	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,476	7,431	19,476	7,431	2,144,977	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	200	0	200	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,374	0	3,374	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,937	0	1,937	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	220	0	220	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	460	0	460	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	560	0	560	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,939	7,431	31,628	7,431	2,144,977	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	0	1,428	0	0	192.00
194.00	07950	MARKETING	21	0	21	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
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)	1,404,093	49,086	317,428	1,177,558	606,747	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.053822	6.605571	9.596638	158.465617	0.282869	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	542,287	557	23,616	295,433	39,556	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	16.241973	0.074956	0.713970	39.756829	0.018441	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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet B-1 | Date/Time Prepared: 7/27/2021 8:18 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,829,588		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,689,700		30.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,657		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	06000	LABORATORY	691,774		60.00
65.00	06500	RESPIRATORY THERAPY	483,821		65.00
66.00	06600	PHYSICAL THERAPY	2,605,460		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,171,444		67.00
68.00	06800	SPEECH PATHOLOGY	919,329		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	528,798		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,072,316		73.00
74.00	07400	RENAL DIALYSIS	262,450		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	99,839		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0		91.00
91.01	04951	OUTPATIENT THERAPY	0		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,829,588		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	MARKETING	0		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0		194.01
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)	141,417		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008403		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	35,095		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002085		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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/27/2021 8:18 pm

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		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	8,348,763		8,348,763	0	8,348,763	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,274		43,274	0	43,274	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	133,339		133,339	0	133,339	60.00
65.00	06500	RESPIRATORY THERAPY	259,391	0	259,391	0	259,391	65.00
66.00	06600	PHYSICAL THERAPY	1,451,843	0	1,451,843	0	1,451,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,178,529	0	1,178,529	0	1,178,529	67.00
68.00	06800	SPEECH PATHOLOGY	409,392	0	409,392	0	409,392	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	350,755		350,755	0	350,755	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	857,353		857,353	0	857,353	73.00
74.00	07400	RENAL DIALYSIS	196,438		196,438	0	196,438	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	196,436		196,436	0	196,436	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0		0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	13,425,513	0	13,425,513	0	13,425,513	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	13,425,513	0	13,425,513	0	13,425,513	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,689,700		6,689,700			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,657	0	304,657	0.142042	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	691,774	0	691,774	0.192749	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	483,821	0	483,821	0.536130	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,989,130	616,330	2,605,460	0.557231	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,874,015	297,429	2,171,444	0.542740	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	771,625	147,704	919,329	0.445316	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	528,798	0	528,798	0.663306	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,072,316	0	2,072,316	0.413717	0.000000	73.00
74.00	07400	RENAL DIALYSIS	262,450	0	262,450	0.748478	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	99,839	0	99,839	1.967528	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0.000000	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	15,768,125	1,061,463	16,829,588			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,768,125	1,061,463	16,829,588			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142042	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.192749	60.00
65.00	06500	RESPIRATORY THERAPY	0.536130	65.00
66.00	06600	PHYSICAL THERAPY	0.557231	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.542740	67.00
68.00	06800	SPEECH PATHOLOGY	0.445316	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663306	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413717	73.00
74.00	07400	RENAL DIALYSIS	0.748478	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	1.967528	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS		117.00
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: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		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	8,348,763		8,348,763	0	8,348,763	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,274		43,274	0	43,274	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	133,339		133,339	0	133,339	60.00
65.00	06500	RESPIRATORY THERAPY	259,391	0	259,391	0	259,391	65.00
66.00	06600	PHYSICAL THERAPY	1,451,843	0	1,451,843	0	1,451,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,178,529	0	1,178,529	0	1,178,529	67.00
68.00	06800	SPEECH PATHOLOGY	409,392	0	409,392	0	409,392	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	350,755		350,755	0	350,755	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	857,353		857,353	0	857,353	73.00
74.00	07400	RENAL DIALYSIS	196,438		196,438	0	196,438	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	196,436		196,436	0	196,436	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0		0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	13,425,513	0	13,425,513	0	13,425,513	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	13,425,513	0	13,425,513	0	13,425,513	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,689,700		6,689,700			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,657	0	304,657	0.142042	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	691,774	0	691,774	0.192749	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	483,821	0	483,821	0.536130	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,989,130	616,330	2,605,460	0.557231	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,874,015	297,429	2,171,444	0.542740	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	771,625	147,704	919,329	0.445316	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	528,798	0	528,798	0.663306	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,072,316	0	2,072,316	0.413717	0.000000	73.00
74.00	07400	RENAL DIALYSIS	262,450	0	262,450	0.748478	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	99,839	0	99,839	1.967528	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0.000000	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	15,768,125	1,061,463	16,829,588			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,768,125	1,061,463	16,829,588			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142042	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.192749	60.00
65.00	06500	RESPIRATORY THERAPY	0.536130	65.00
66.00	06600	PHYSICAL THERAPY	0.557231	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.542740	67.00
68.00	06800	SPEECH PATHOLOGY	0.445316	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663306	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413717	73.00
74.00	07400	RENAL DIALYSIS	0.748478	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	1.967528	76.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS		117.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,274	1,097	42,177	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	133,339	2,890	130,449	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	259,391	16,920	242,471	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,451,843	239,481	1,212,362	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,178,529	143,037	1,035,492	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	409,392	20,933	388,459	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	350,755	34,676	316,079	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	857,353	50,182	807,171	0	0	73.00
74.00	07400	RENAL DIALYSIS	196,438	2,752	193,686	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	196,436	2,429	194,007	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
200.00		Subtotal (sum of lines 50 thru 199)	5,076,750	514,397	4,562,353	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	5,076,750	514,397	4,562,353	0	0	202.00

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

Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet C Part II | Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,274	304,657	0.142042		54.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
60.00	06000	LABORATORY	133,339	691,774	0.192749		60.00
65.00	06500	RESPIRATORY THERAPY	259,391	483,821	0.536130		65.00
66.00	06600	PHYSICAL THERAPY	1,451,843	2,605,460	0.557231		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,178,529	2,171,444	0.542740		67.00
68.00	06800	SPEECH PATHOLOGY	409,392	919,329	0.445316		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	350,755	528,798	0.663306		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	857,353	2,072,316	0.413717		73.00
74.00	07400	RENAL DIALYSIS	196,438	262,450	0.748478		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	196,436	99,839	1.967528		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0.000000		91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0.000000		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
117.00	06950	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0.000000		117.00
200.00		Subtotal (sum of lines 50 thru 199)	5,076,750	10,139,888			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	5,076,750	10,139,888			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,678,782	0	1,678,782	7,431	225.92	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,678,782		1,678,782	7,431		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	4,658	1,052,335		30.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30 through 199)	4,658	1,052,335		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,097	304,657	0.003601	205,330	739	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	2,890	691,774	0.004178	520,659	2,175	60.00
65.00	06500	RESPIRATORY THERAPY	16,920	483,821	0.034972	308,828	10,800	65.00
66.00	06600	PHYSICAL THERAPY	239,481	2,605,460	0.091915	1,242,085	114,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,037	2,171,444	0.065872	1,188,915	78,316	67.00
68.00	06800	SPEECH PATHOLOGY	20,933	919,329	0.022770	499,410	11,372	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,676	528,798	0.065575	295,150	19,354	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,182	2,072,316	0.024215	1,294,669	31,350	73.00
74.00	07400	RENAL DIALYSIS	2,752	262,450	0.010486	122,650	1,286	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	2,429	99,839	0.024329	66,849	1,626	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	514,397	10,139,888		5,744,545	271,184	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,431	0.00	4,658	30.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	7,431		4,658	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	304,657	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	691,774	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	483,821	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,605,460	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,171,444	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	919,329	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	528,798	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,072,316	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	262,450	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	99,839	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	10,139,888		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	205,330	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	520,659	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	308,828	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,242,085	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,188,915	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	499,410	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	295,150	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,294,669	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	122,650	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	66,849	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,744,545	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142042	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.192749	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.536130	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.557231	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.542740	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.445316	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663306	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413717	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.748478	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	1.967528	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part V Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
91.01	04951	OUTPATIENT THERAPY	0	0		91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part I Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,678,782	0	1,678,782	7,431	225.92	30.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,678,782		1,678,782	7,431		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	191	43,151		30.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30 through 199)	191	43,151		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part II Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,097	304,657	0.003601	0	0	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	2,890	691,774	0.004178	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	16,920	483,821	0.034972	0	0	65.00
66.00	06600	PHYSICAL THERAPY	239,481	2,605,460	0.091915	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,037	2,171,444	0.065872	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,933	919,329	0.022770	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,676	528,798	0.065575	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,182	2,072,316	0.024215	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,752	262,450	0.010486	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	2,429	99,839	0.024329	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	514,397	10,139,888		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part III Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,431	0.00	191	30.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	7,431		191	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	304,657	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	691,774	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	483,821	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,605,460	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,171,444	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	919,329	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	528,798	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,072,316	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	262,450	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	99,839	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	04951	OUTPATIENT THERAPY	0	0	0	0	0.000000	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0	0	0	0	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	10,139,888		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D Part IV Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,431	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,431	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)	7,431	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	4,658	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	8,348,763	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,348,763	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)	8,348,763	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,123.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,233,263	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)	5,233,263	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	2,809,619	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,042,882	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)	1,052,335	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	271,184	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,323,519	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,719,363	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,678,782	8,348,763	0.201082	0	0	90.00
91.00	Nursing School cost	0	8,348,763	0.000000	0	0	91.00
92.00	Allied health cost	0	8,348,763	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,348,763	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 8:18 pm

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	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)	7,431	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,431	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)	7,431	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	191	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	8,348,763	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,348,763	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)	8,348,763	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,123.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	214,589	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)	214,589	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	214,589	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)	43,151	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)	43,151	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	171,438	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-1 | Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,678,782	8,348,763	0.201082	0	0	90.00
91.00	Nursing School cost	0	8,348,763	0.000000	0	0	91.00
92.00	Allied health cost	0	8,348,763	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,348,763	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,192,200		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142042	205,330	29,165	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.192749	520,659	100,357	60.00
65.00	06500	RESPIRATORY THERAPY	0.536130	308,828	165,572	65.00
66.00	06600	PHYSICAL THERAPY	0.557231	1,242,085	692,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.542740	1,188,915	645,272	67.00
68.00	06800	SPEECH PATHOLOGY	0.445316	499,410	222,395	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663306	295,150	195,775	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413717	1,294,669	535,627	73.00
74.00	07400	RENAL DIALYSIS	0.748478	122,650	91,801	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	1.967528	66,849	131,527	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,744,545	2,809,619	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)		5,744,545		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | Date/Time Prepared: 7/27/2021 8:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142042	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.192749	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.536130	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.557231	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.542740	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.445316	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663306	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413717	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.748478	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	1.967528	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.000000	0	0	91.00
91.01	04951	OUTPATIENT THERAPY	0.000000	0	0	91.01
93.00	04950	OUTPATIENT WOUND CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/27/2021 8:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	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)	0	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)	0	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)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	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)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	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	0	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)	0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet E-1 Part I Date/Time Prepared: 7/27/2021 8:18 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,482,180		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)		7,482,180		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		996		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,483,176		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	Provider CCN: 15-3042	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prepared: 7/27/2021 8:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7,304,994	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0155	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	235,221	3.00
4.00	Outlier Payments	101,327	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	20.303279	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	7,641,542	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	7,641,542	17.00
18.00	Primary payer payments	10,000	18.00
19.00	Subtotal (line 17 less line 18).	7,631,542	19.00
20.00	Deductibles	67,364	20.00
21.00	Subtotal (line 19 minus line 20)	7,564,178	21.00
22.00	Coinsurance	41,888	22.00
23.00	Subtotal (line 21 minus line 22)	7,522,290	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,313	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	10,603	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,108	26.00
27.00	Subtotal (sum of lines 23 and 25)	7,532,893	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	7,532,893	32.00
32.01	Sequestration adjustment (see instructions)	49,717	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	7,482,180	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	996	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	101,327	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G | Date/Time Prepared: 7/27/2021 8:18 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	19,563	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,542,309	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,452,811	0	0	0	6.00
7.00	Inventory	74,462	0	0	0	7.00
8.00	Prepaid expenses	233,810	0	0	0	8.00
9.00	Other current assets	16,752	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)	2,434,085	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	78,186	0	0	0	15.00
16.00	Accumulated depreciation	-8,970	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	22,178	0	0	0	19.00
20.00	Accumulated depreciation	-19,650	0	0	0	20.00
21.00	Automobiles and trucks	61,836	0	0	0	21.00
22.00	Accumulated depreciation	-12,388	0	0	0	22.00
23.00	Major movable equipment	2,664,491	0	0	0	23.00
24.00	Accumulated depreciation	-1,855,674	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)	930,009	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	135,809,991	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	135,809,991	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	139,174,085	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	296,126	0	0	0	37.00
38.00	Salaries, wages, and fees payable	456,726	0	0	0	38.00
39.00	Payroll taxes payable	344,991	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	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	153,091,241	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	154,189,084	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	278,460	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	920,536	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,198,996	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	155,388,080	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-16,213,995				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)	-16,213,995	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	139,174,085	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-1 | Date/Time Prepared: 7/27/2021 8:18 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-15,361,679		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-852,316				2.00
3.00	Total (sum of line 1 and line 2)		-16,213,995		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-16,213,995		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-16,213,995		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/27/2021 8:18 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,689,700		6,689,700	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,689,700		6,689,700	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)	6,689,700		6,689,700	17.00
18.00	Ancillary services	9,078,426	1,061,462	10,139,888	18.00
19.00	Outpatient services	0	0	0	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,768,126	1,061,462	16,829,588	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,244,215		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)		13,244,215		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-3042 | Period: From 01/01/2020 To 12/31/2020 | Worksheet G-3 | Date/Time Prepared: 7/27/2021 8:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	16,829,588	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5,271,742	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,557,846	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,244,215	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,686,369	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	143	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	9,005	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	51	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	MISC INC, TRANSPORT, EMP PHYS SVCS	222,530	24.00
24.50	COVID-19 PHE Funding	602,324	24.50
25.00	Total other income (sum of lines 6-24)	834,053	25.00
26.00	Total (line 5 plus line 25)	-852,316	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)	-852,316	29.00